

11369

11354

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 1084 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 22 S. Athol Ave	
3. NAME OF DECEASED (Type or print) First Gertrude F. Middle - Last Billmyer		4. DATE OF DEATH Month 10 Day 25 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1871
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Household	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilhelm Ritter		14. MOTHER'S MAIDEN NAME Katherine Schanze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 220-20-2892 B	
17. INFORMANT Record of Victor Cullen Hosp.		Address Record of Victor Cullen Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - 002 DUE TO (b) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) 002X DUE TO (c) 002X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arteriosclerosis - 450			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/6 to 10/25 , 19 61 , that (I) (we) lost saw the deceased alive on 10/25 , 19 61 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE M. Davis		22b. DATE SIGNED 10/25/61	
22c. PHYSICIAN'S NAME (Type) Michael S. Davis		22d. ADDRESS Cullen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-28-61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Bragan		25. REC'D BY REGISTRAR Thurmont Md	
25a. REGISTRAR'S SIGNATURE Arthur S. Krause		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

1321

100-100000

100-100000

100-100000

M

1

The following is a list of the names of the persons who have been named in the various reports of the Committee on the subject of the proposed amendment to the Constitution of the United States. The names are given in alphabetical order, and are followed by the name of the person or persons to whom they have been referred. The names are given in the order in which they were received by the Committee.

The following is a list of the names of the persons who have been named in the various reports of the Committee on the subject of the proposed amendment to the Constitution of the United States. The names are given in alphabetical order, and are followed by the name of the person or persons to whom they have been referred. The names are given in the order in which they were received by the Committee.

11370

CERTIFICATE OF DEATH

Reg. Dist. No.

11355

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First George Middle Raymond Last Bowers				4. DATE OF DEATH Month 10 Day 12 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/1894	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Bowers				14. MOTHER'S MAIDEN NAME Ella F. Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charlotte Bowers, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma left Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to Brain DUE TO (c) Metastasis to Brain						INTERVAL BETWEEN ONSET AND DEATH 7 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 61 , to Oct 12 19 61 , that I last saw the deceased alive on Oct 12 19 61 , and that death occurred at 4:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J Elmer Harp M.D. Middletown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial							
22b. DATE THEREOF 10/15/1961		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR Oct 17 '61		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11520

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1880		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 25 1945		BALTIMORE, MD	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
NONE		JAN 20 1945		JAN 25 1945		10:00 AM		10:00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 25 1945		JAN 25 1945		JAN 25 1945		JAN 25 1945		JAN 25 1945		JAN 25 1945	

(M)

RECEIVED
JAN 26 1945
BALTIMORE, MD

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the delay should be noted in the space provided. The certificate should be executed by the funeral director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11371 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11356

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>213 Jefferson St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> d. STREET ADDRESS <u>213 Jefferson St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Elwood</u> Last <u>Bowie</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/1900</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>garage</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Bowie</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Laison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-0832</u> 17. INFORMANT <u>Mrs. Edith Bowie, Middletown, Md.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B O Thomas</u> EXAMINER'S NAME (Type) <u>Dr. B. O. Thomas</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE, SIGNED <u>Oct. 16, 1961</u> Address (Street, city, town, or county) <u>Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/18/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or country) <u>Middletown, Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR <u>Gladhill Company, Middletown, Md.</u> ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>OCT 17 '61</u> DATE <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

1931

RECEIVED JAN 10 1931

M

T

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after the death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11372 CERTIFICATE OF DEATH 11357											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Since 9/29/61 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown d. STREET ADDRESS 111 Jefferson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GOLDYE MAE BRANDENBURG						4. DATE OF DEATH Month October Day 8 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 March 1895		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk				10b. KIND OF BUSINESS OR INDUSTRY Pastry Shop				11. BIRTHPLACE (County & State, or foreign country) Kemptown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar M. Brandenburg						14. MOTHER'S MAIDEN NAME Mary Jane Baker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-26-5483		17. INFORMANT Glenn H. Brandenburg (Same as item #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 572.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5/10/61											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1958 to Oct 8, 1961 , that (I) (we) last saw the deceased alive on Oct 8, 1961 , and that death occurred 5:40 P.M. from the causes and on the date stated above.											
22a. SIGNATURE B. O. Thomas M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10 Oct 1961		
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.						22d. ADDRESS 228 N. Market St., Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-11-61		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery			23d. LOCATION (City, town or county) (State) Kemptown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md.						25a. REC'D BY REGISTRAR OCT 11 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

11331

UNITED STATES

11331



RECEIVED
JAN 10 1961
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.
20535
FROM: SAC, NEW YORK (100-111111)
TO: DIRECTOR, FBI (100-441111)
SUBJECT: [Illegible]
[Illegible text follows]



[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A18 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11373						11358					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Frederick MARYLAND						a. STATE Maryland Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
c. LENGTH OF STAY IN 1b Lifetime						d. STREET ADDRESS 407 East Patrick St.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monocacy Hall Nursing Home						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED						4. DATE OF DEATH					
(Type or print) Anna Rosetta Burger						Month Day Year Oct. 29 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5-1871		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (County & State, or foreign country) Frederick County- Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Wm. Henry Burger				14. MOTHER'S MAIDEN NAME Anna Margaretha Drarer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. W. Leslie Burger- Culler Ave.-Frederick-Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1960 to Oct. 29, 1961 , that (I) (we) last saw the deceased alive on Oct. 28, 1961 , and that death occurred at 5:15A. from the causes and on the date stated above.											
22a. SIGNATURE B. O. Thomas M.D.											
22b. DATE SIGNED 10/30/61											
22c. PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Sr.											
22d. ADDRESS Professional Bldg.- Frederick- Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Oct. 31-1961											
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery											
23d. LOCATION (City, town or county) (State) Frederick- Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Dailey's Funeral Home- Frederick- Md. By E. J. Whitmore											
25a. REC'D BY REGISTRAR DATE NOV 2 '61											
25b. REGISTRAR'S SIGNATURE Charles S. Kline											

M

Frederick

Maryland

Frederick

Frederick

Monocacy Hall Hunting House

107 East Patrick St.

June

November

August

Oct. 20

Female White

May 2-1871

30

None

Frederick County - Maryland

U.S.A.

Mr. Henry Burger

Miss Margaretta Burger

No

None

Mr. W. Leslie Burger - Officer 1st - Frederick - Md.

1872

Mr. S. S. Thomas - Jr.

Professional High - Frederick - Md.

Burial

Oct. 21-1861 Md. Silver Cemetery

Frederick - Md.

Calley's Funeral Home - Frederick - Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

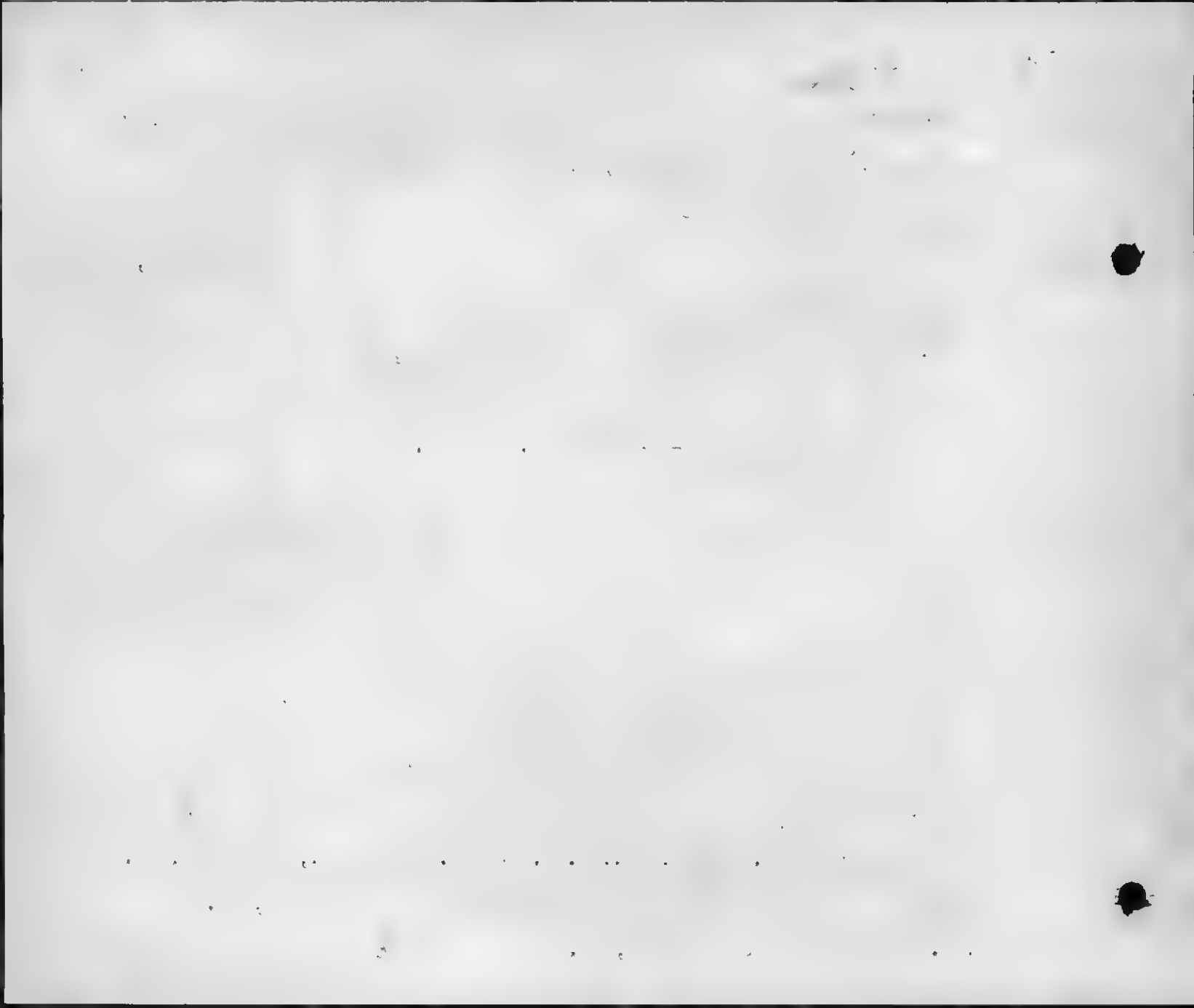
11374

11359

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY in b. Since 9/22/61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MEDORA Middle IRENE Last BURNS		4. DATE OF DEATH Month October Day 8 Year 19 61	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 April 1896 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (County & State or foreign country) Jefferson, Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Alice Alberta Lamm	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-03-4752 17. INFORMANT Mrs. Alice N. Kabrick (Same as item #2) Address		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 153.2 DUE TO (b) Obstruction of ureters by metastatic tumor (c) Carcinoma of descending Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized metastases from (c) above. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 10 24 Hour a.m. 8:00 p.m. 3:50P 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 24 Oct 1958 to 8 Oct 1961 20f. (City or town) Frederick, Md. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 Oct 1958 to 8 Oct 1961 , that (I) (we) last saw the deceased alive on 8 Oct 1961 , and that death occurred at 3:50P , from the causes and on the date stated above.		22a. SIGNATURE Charles H. Conley, Jr. M.D. 22b. DATE SIGNED 10 Oct 1961 22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D. 22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 10-11-61 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 23d. LOCATION (City, town or county) Frederick, Md. (State)		24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Md. ADDRESS 25a. REC'D BY REGISTRAR OCT 11 '61 25b. REGISTRAR'S SIGNATURE Charles E. Howard	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

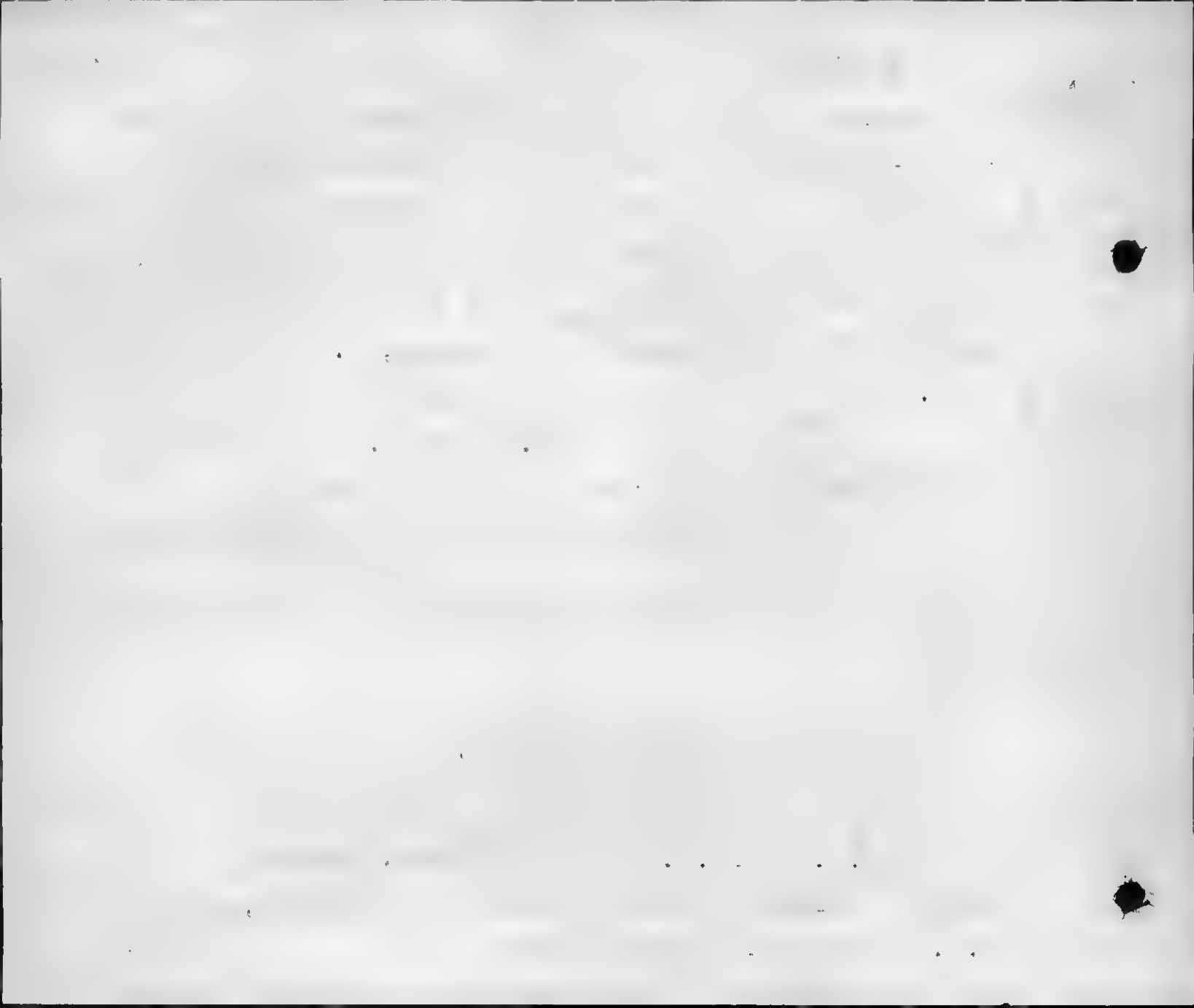
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11375

CERTIFICATE OF DEATH

11360

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5 c. LENGTH OF STAY IN 1b 8 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Braddock				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5 d. STREET ADDRESS Old Braddock e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First ADA Middle MARY Last DARNER		4. DATE OF DEATH Month October Day 5 Year 19 61		5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 25 Sept 1862 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 99 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Middletown, Md.		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME John J. Smith				14. MOTHER'S MAIDEN NAME Mary Koogle											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Katherine D. Jenkins (Same as item #2) Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (b) Advanced generalized arteriosclerosis 10 yrs (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8/2, 1961 to 10/5, 1961, that (I) (we) last saw the deceased alive on 10/4 1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above.															
22a. SIGNATURE <i>A. T. Brice</i> M.D.				22b. DATE SIGNED 6 Oct 1961				22c. PHYSICIAN'S NAME (Type) A. T. Brice, M. D.				22d. ADDRESS Jefferson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-8-61				23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery				23d. LOCATION (City, town or county) (State) Middletown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland												25a. REC'D BY REGISTRAR OCT 9 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

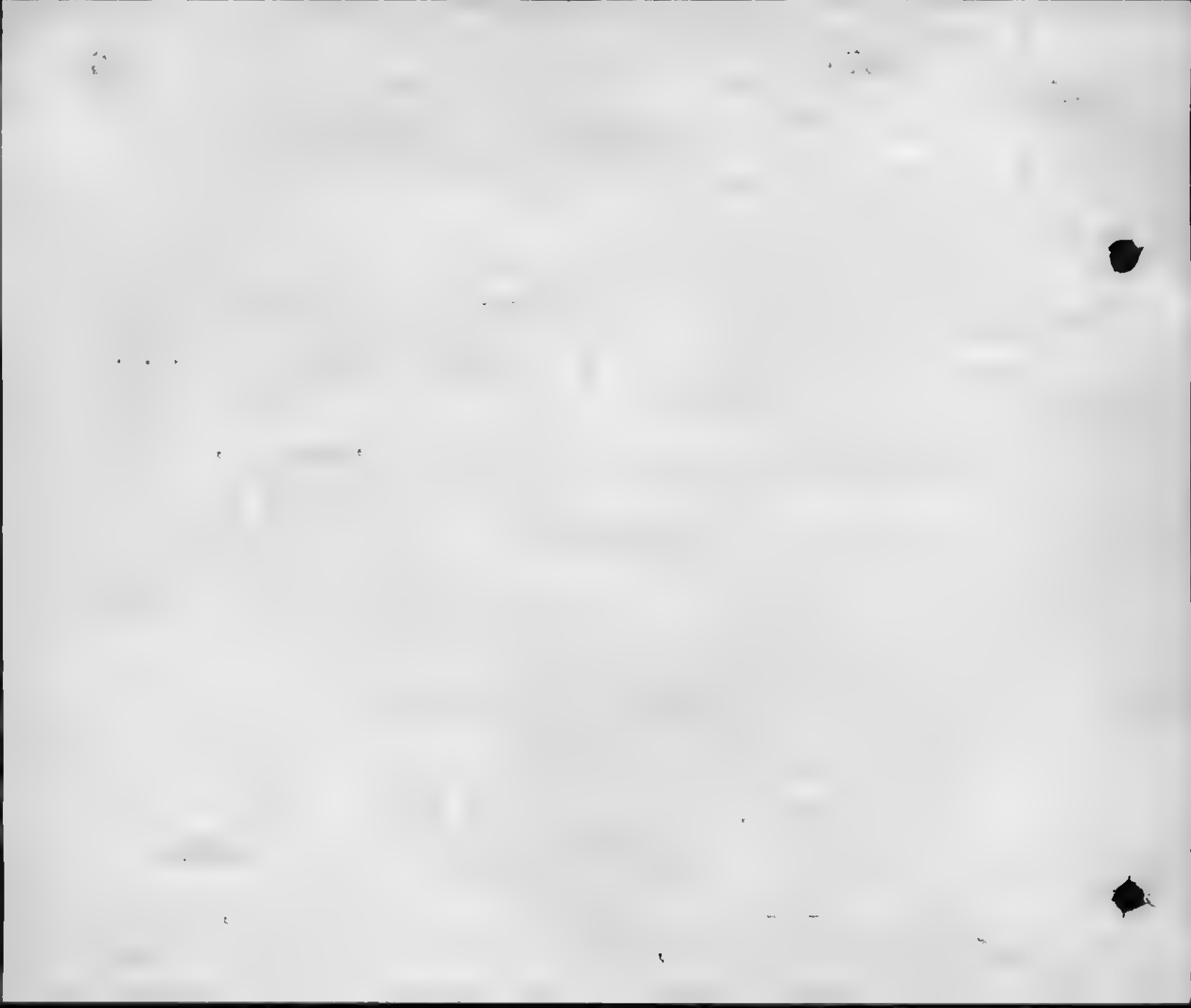
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11376

CERTIFICATE OF DEATH

11361

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick	
c. LENGTH OF STAY N 1b		d. STREET ADDRESS 9 East "B"	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Randy Allen Dawson		4. DATE OF DEATH 10 17 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1961	
9. AGE (In years last birthday) 17		IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Dawson		14. MOTHER'S MAIDEN NAME Anna Forbaek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Dawson, Brunswick, Maryland		Address Brunswick, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Developmental neurological defect. DUE TO (b) neurological Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) defect. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-1-61 to 10-17-61 , that (I) (we) last saw the deceased alive on 10-17-61 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. E. PRUITT		22b. DATE SIGNED 10-25-61	
22c. PHYSICIAN'S NAME (Type) C. E. PRUITT		22d. ADDRESS BRUNSWICK MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61	
23c. NAME OF CEMETERY OR CREMATORY Park Heights		23d. LOCATION (City, town or county) (State) Brunswick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus		25a. REC'D BY REGISTRAR OCT 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		DATE	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

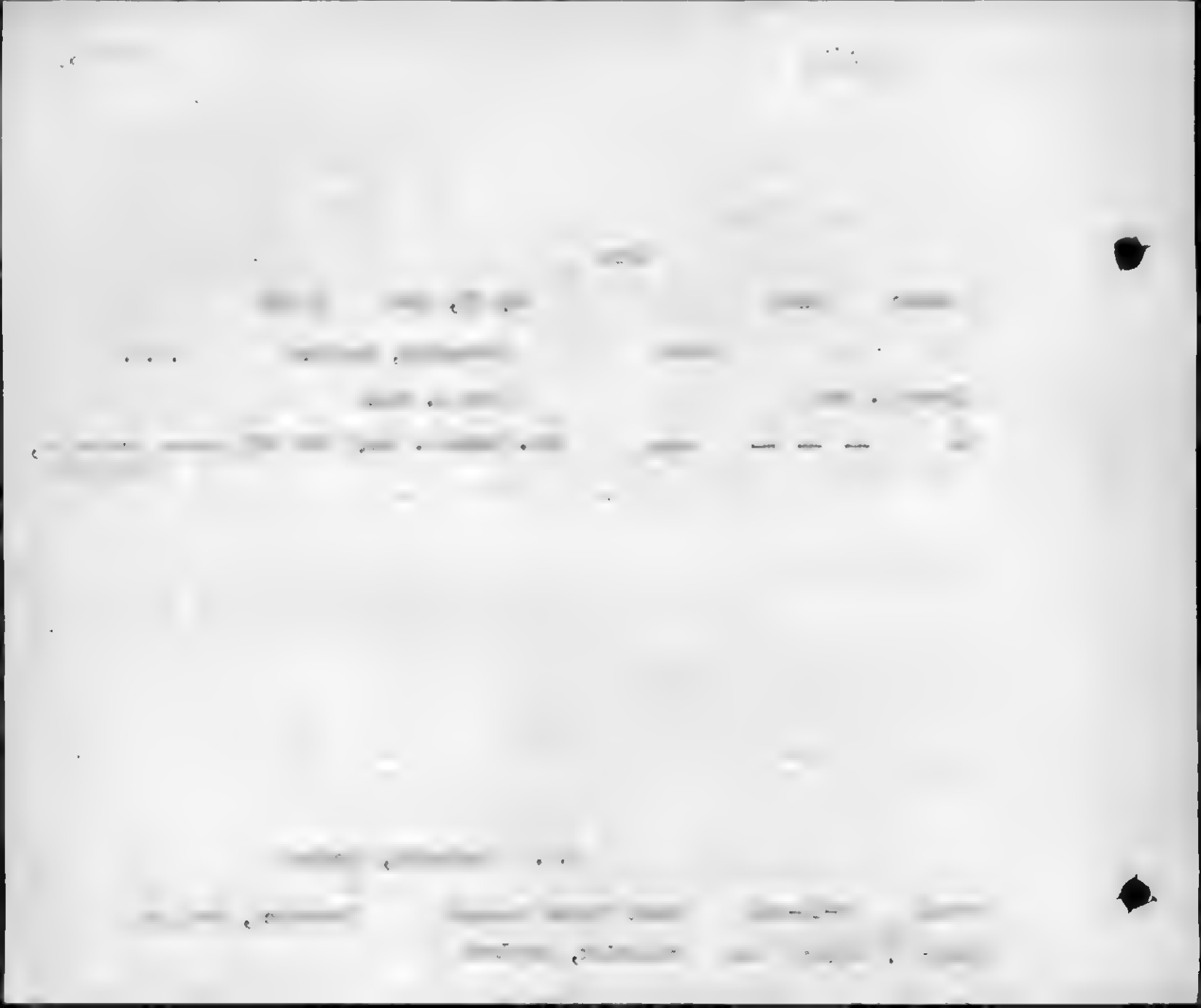
11377

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11362

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FRED. MEM. Hosp		d. STREET ADDRESS 202 Dill Ave	
3. NAME OF DECEASED (Type or print) First Nina Middle Myra Last Derr		4. DATE OF DEATH Month Oct Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert J. Derr		14. MOTHER'S MAIDEN NAME Mary C. Nuss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Zulma J. Derr		Address 202 Dill Avenue Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease DUE TO (b) 20 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (the physician) attended the deceased from Aug 1 , 1961, to Oct 12 , 1961, that (I) last saw the deceased alive on 12 Oct , 1961, and that death occurred at 12 AM , from the causes and on the date stated above			
22a. SIGNATURE JR Poirier		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JR POIRIER		22d. ADDRESS Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-1961	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son		25a. REC'D BY REGISTRAR DATE OCT 16 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hume			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by a funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

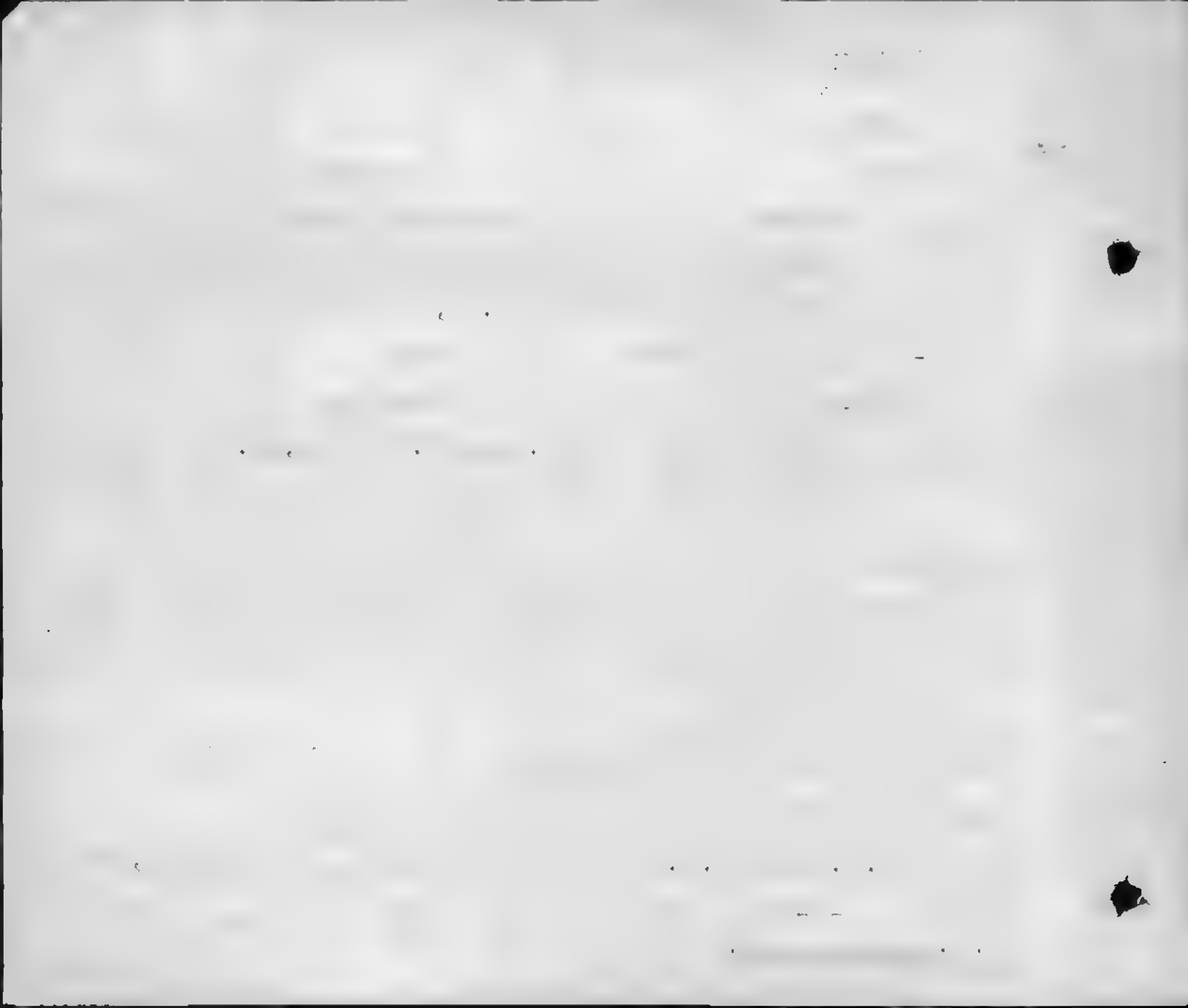
FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11363											
1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 117 East 6th Street				d. STREET ADDRESS 117 East 6th Street							
3. NAME OF DECEASED (Type or print) ELSIE MAE DEVILBISS				4. DATE OF DEATH October 27 19 61				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1903		9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work at home				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Fogle				14. MOTHER'S MAIDEN NAME Nettie Suman				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT Mr. George W. Devilbiss, Sr. (Same as item #1)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis											
420.1 DUE TO (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____				20g. (County) _____				20h. (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE B. O. Thomas				M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED October 28, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-31-1961				22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			
22d. LOCATION (City, town, or country) Frederick				22e. (County) Maryland				22f. (State) Maryland			
23. FUNERAL DIRECTOR M. R. Etchison and Son, Frederick, Maryland											
24a. REC'D BY REGISTRAR NOV 1 '61											
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											



INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be signed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

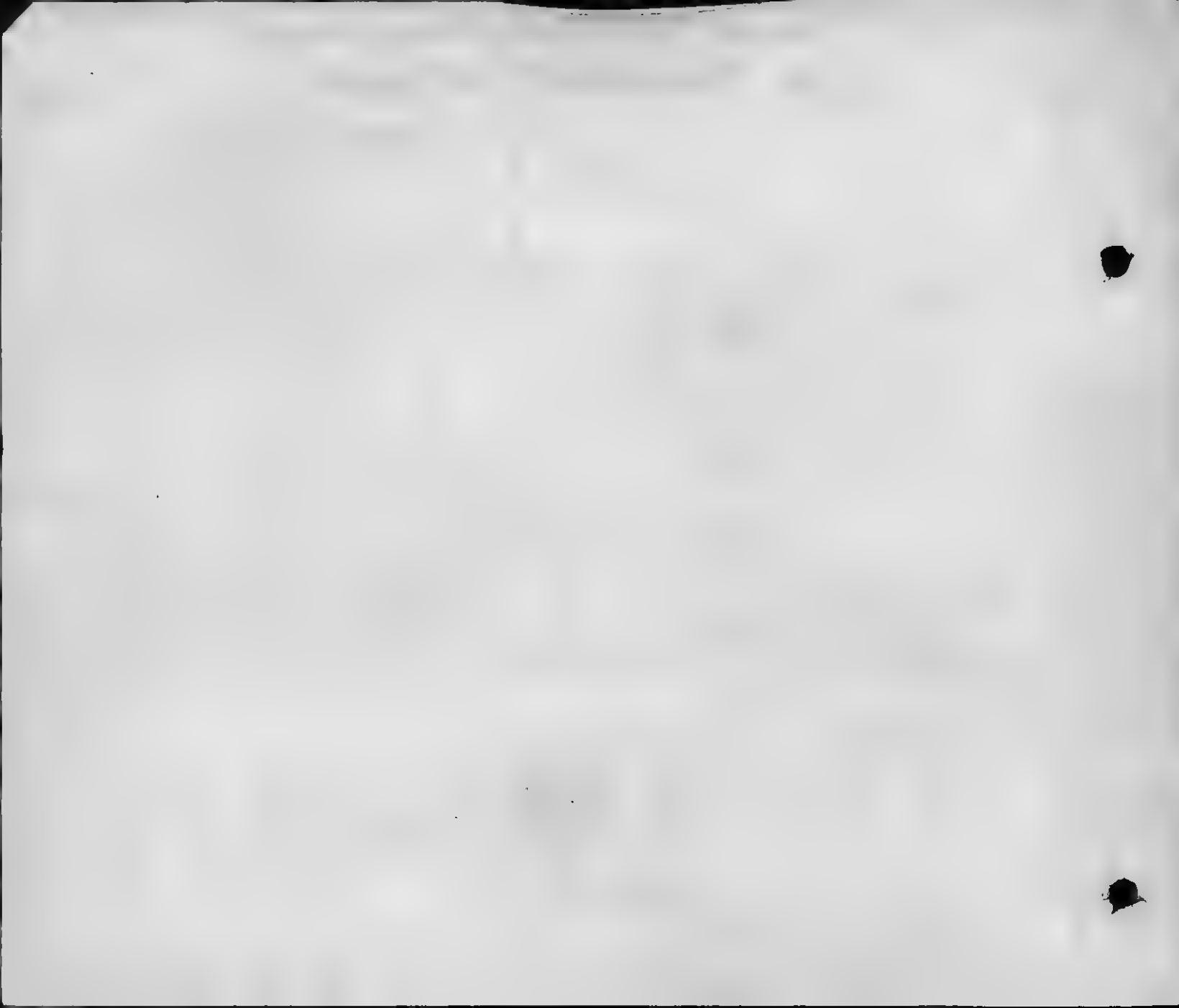
Item 7 Film G297 10/16/61 iwk

11379

CERTIFICATE OF DEATH

Reg. Dist. No. 11365

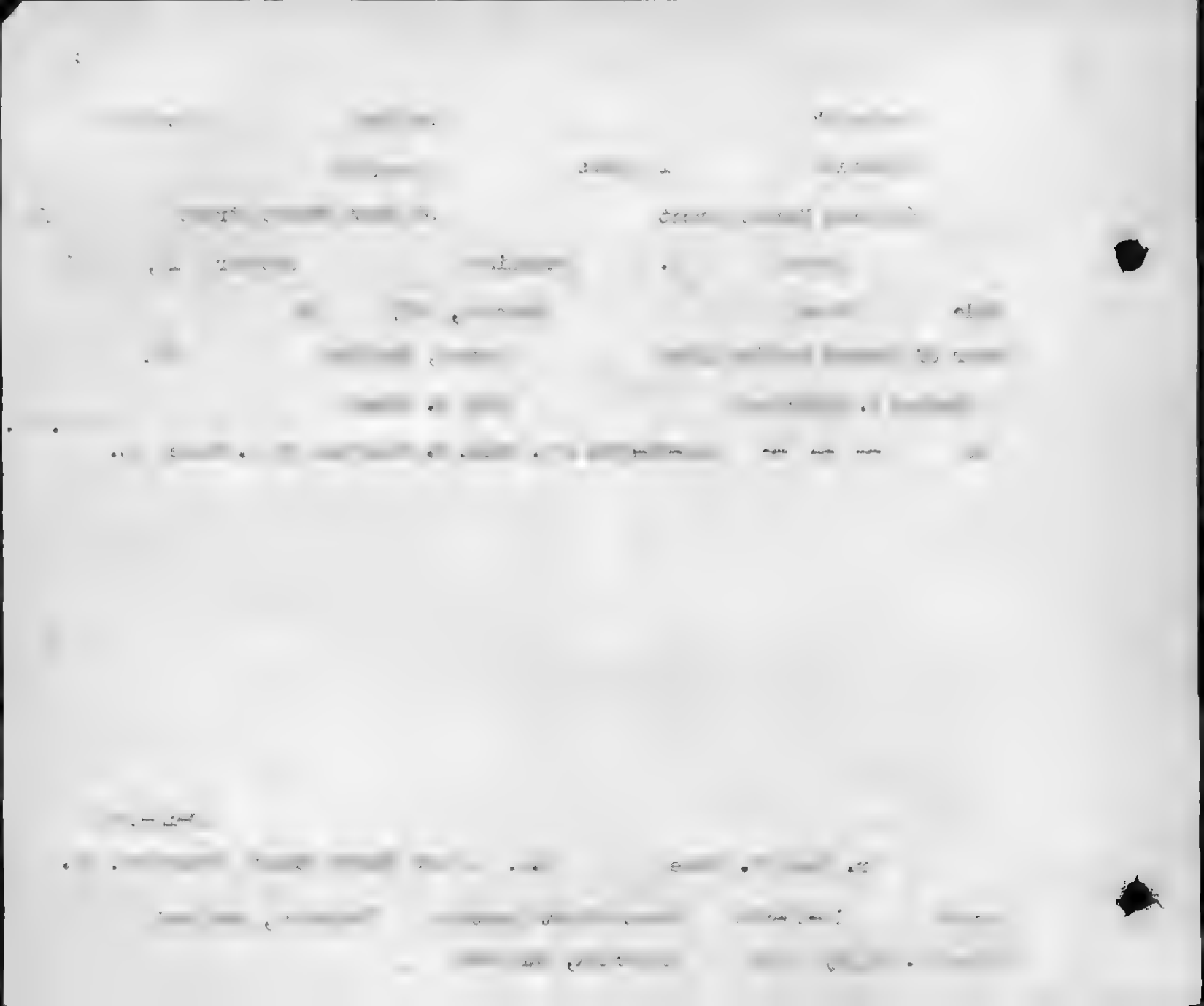
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>		COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
TOWN <u>NEW WINDSOR RURAL</u>		<u>YEARS</u>		TOWN <u>NEW WINDSOR RURAL</u>		<u>YEARS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SAMS CREEK</u>				STREET ADDRESS (If rural give location) <u>SAMS CREEK</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>EMORY ECKER</u>				<u>Oct. 5 1961</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>WIDOWED</u>	<u>JAN 4-1875</u>	<u>86</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARM</u>		<u>BY DAY FARM</u>		<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>FREDERICK ECKER</u>				<u>SARAH FRITZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>120-10-5919</u>		<u>PEARLIE HOOPER NEW WINDSOR</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>42-1</u> <u>Ischemic heart disease</u>						<u>Approx. 1 hr.</u>	
2. ANTECEDENT CAUSE(S) DUE TO							
<u>2. Coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct 29</u>, 19<u>54</u>, to <u>Oct 5</u>, 19<u>61</u>, that I last saw the deceased alive on <u>Oct 5</u>, 19<u>61</u>, and that death occurred at <u>3:00 P</u>M, from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS (Street, city, town, state)			
<u>W. H. Ecker</u>		<u>Oct 6, 1961</u>		<u>Wallerstown, Ind.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT 8-1961</u>		<u>BETHEL</u>		<u>NEW WINDSOR RURAL MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE OCT 10 '61</u>		<u>W. H. Ecker</u>		<u>W. H. Ecker</u>		<u>New Windsor</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11380						11366					
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY in 1b 13 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 60 South Market Street						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 60 South Market Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George F. Federline						4. DATE OF DEATH October 13, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1897		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Diamond Bowling Alley						10b. KIND OF BUSINESS OR INDUSTRY Laurel, Maryland		11. BIRTHPLACE (County & State, or foreign country) USA			
13. FATHER'S NAME Charles E. Federline						14. MOTHER'S MAIDEN NAME Mary E. Bryant					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No						16. SOCIAL SECURITY NO. 218-22-4506					
17. INFORMANT Mrs. Della M. Federline						Address 60 S. Market St. Fred. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary heart disease (c) 6 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 30 min					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from Oct 12 to Oct 13 , 1961, that (I) (we) last saw the deceased alive on Oct 13 , 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Henry V Chase M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-14-1961			
22c. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase						22d. ADDRESS M.D. 4 East Church Street Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-1961		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son						ADDRESS Frederick, Maryland		DATE OCT 17 '61		Signature Robert E. Dailey	

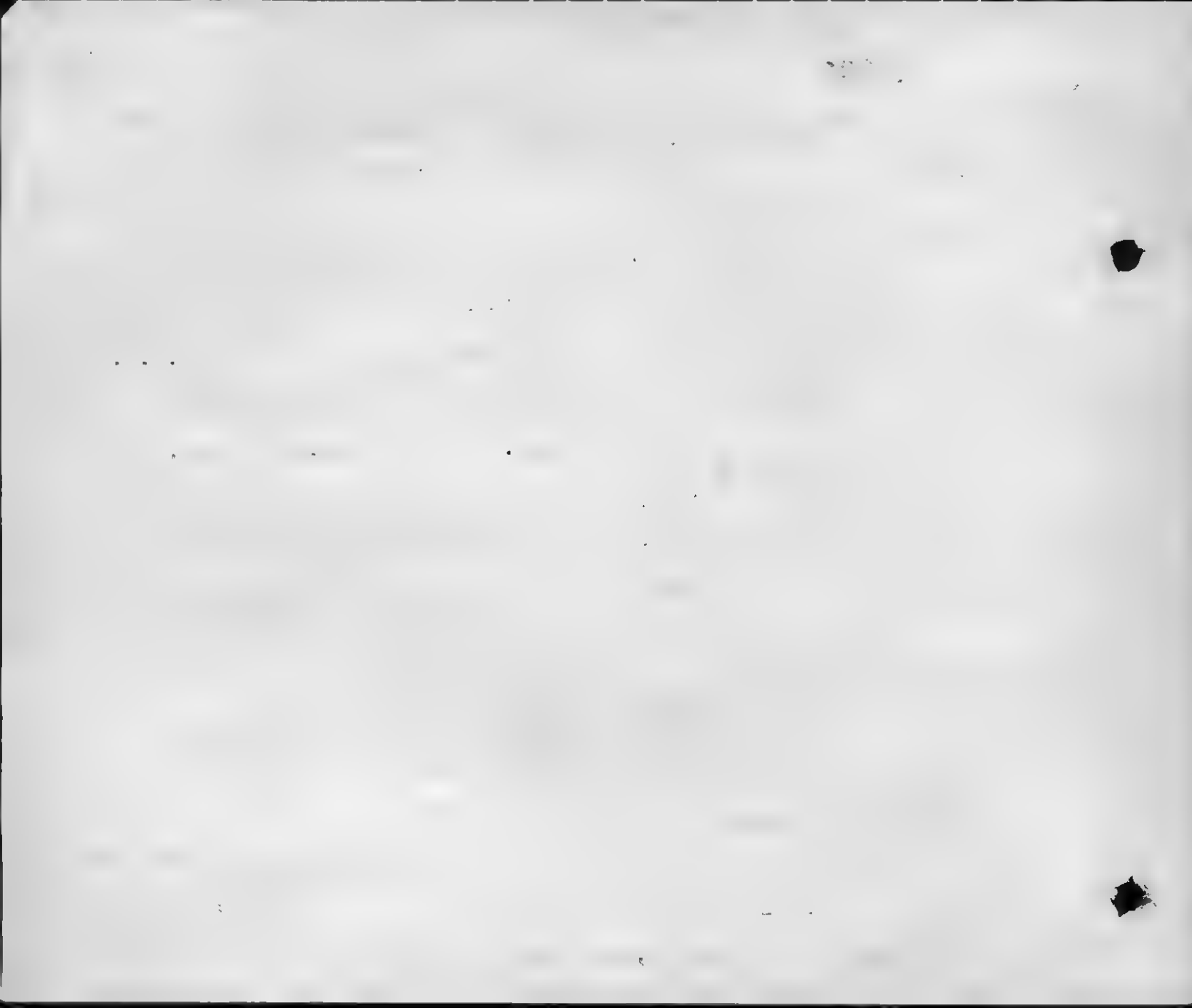


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11381
11367
CERTIFICATE OF DEATH

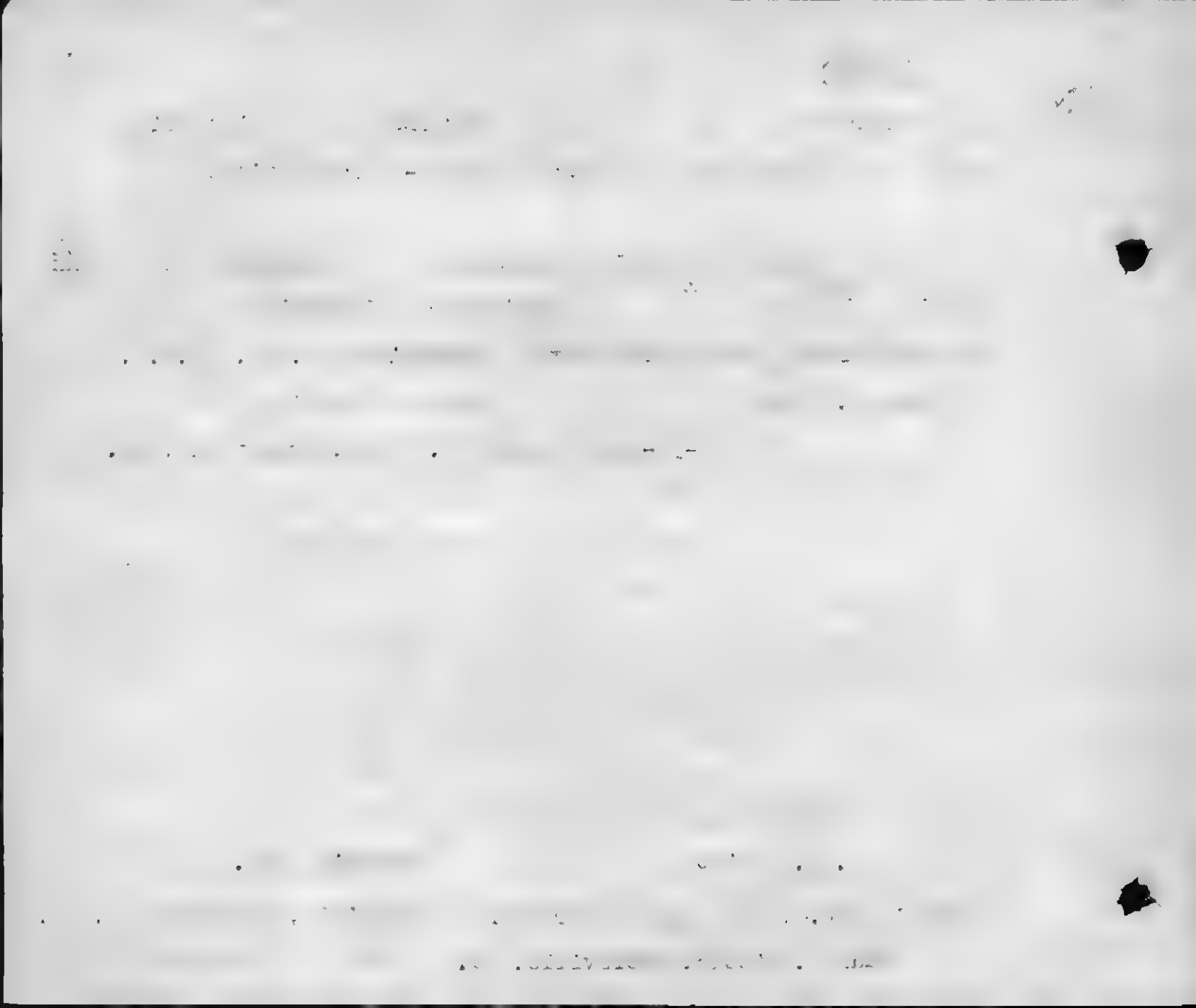
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 9th Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick d. STREET ADDRESS 102 9th Avenue	
3. NAME OF DECEASED (Type or print) Edgar Martin Harmon		4. DATE OF DEATH Month 10 Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1900
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Harmon		14. MOTHER'S MAIDEN NAME Emma Kidwilder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO., 17. INFORMANT Mrs. Sarah Garrett, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Death following pneumonia Conditions, if any, which gave rise to immediate cause (b) Hypertension (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 2-4 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 10-10-1961			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Brunswick (County) Maryland (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-10-1961 to 10-10-1961 , that (I) (we) saw the deceased alive on 10-10-1961 , and that death occurred 5:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE C. E. PRUITT M.D.			
22b. DATE SIGNED 10-12-61			
22c. PHYSICIAN'S NAME (Type) C. E. PRUITT			
22d. ADDRESS BRUNSWICK MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 10-12-1961			
23c. NAME OF CEMETERY OR CREMATORY Park Heights			
23d. LOCATION (City, town or county) Brunswick, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE B. H. FULTON ADDRESS Brunswick, Maryland			
25a. REC'D BY REGISTRAR OCT 17 61 DATE			
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11382											
11368											
1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Burkittsville							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Burkittsville				c. LENGTH OF STAY IN TB 17 years				d. STREET ADDRESS Rural - Burkittsville			
d. NAME OF HOSPITAL OR INSTITUTION (If no in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT EARL HARNE				4. DATE OF DEATH Month Day Year October 1 1961				9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours M.n. 71 yrs.			
5. SEX male				6. COLOR OR RACE white				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH September 20, 1890				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer own general farm				11. BIRTHPLACE (County & State, or foreign country) Frederick, Co. Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James O. Harne				14. MOTHER'S MAIDEN NAME Anna Mae Burrier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 219-36-0094				17. INFORMANT James R. Harne, Myersville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Carcinoma of rt. lung Regional metastasis Sarcinoma				INTERVAL BETWEEN ONSET AND DEATH 9 mos.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-20-61 to 10-1-61 , that (I) (we) last saw the deceased alive on 9-20-61 , and that death occurred at 6:25 M., from the causes and on the date stated above.											
22a. SIGNATURE C. E. Pruitt				22b. DATE SIGNED Oct 5 '61				22c. PHYSICIAN'S NAME (Type) C. E. Pruitt			
22d. ADDRESS Brunswick, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF Oct. 4, 1961				23c. NAME OF CEMETERY OR CREMATORY United Brethern			
23d. LOCATION (City, town or county) Garfield, Frederick Co. Md.				23e. REC'D BY REGISTRAR Paul F. Bittle, Myersville, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				24a. ADDRESS Myersville, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

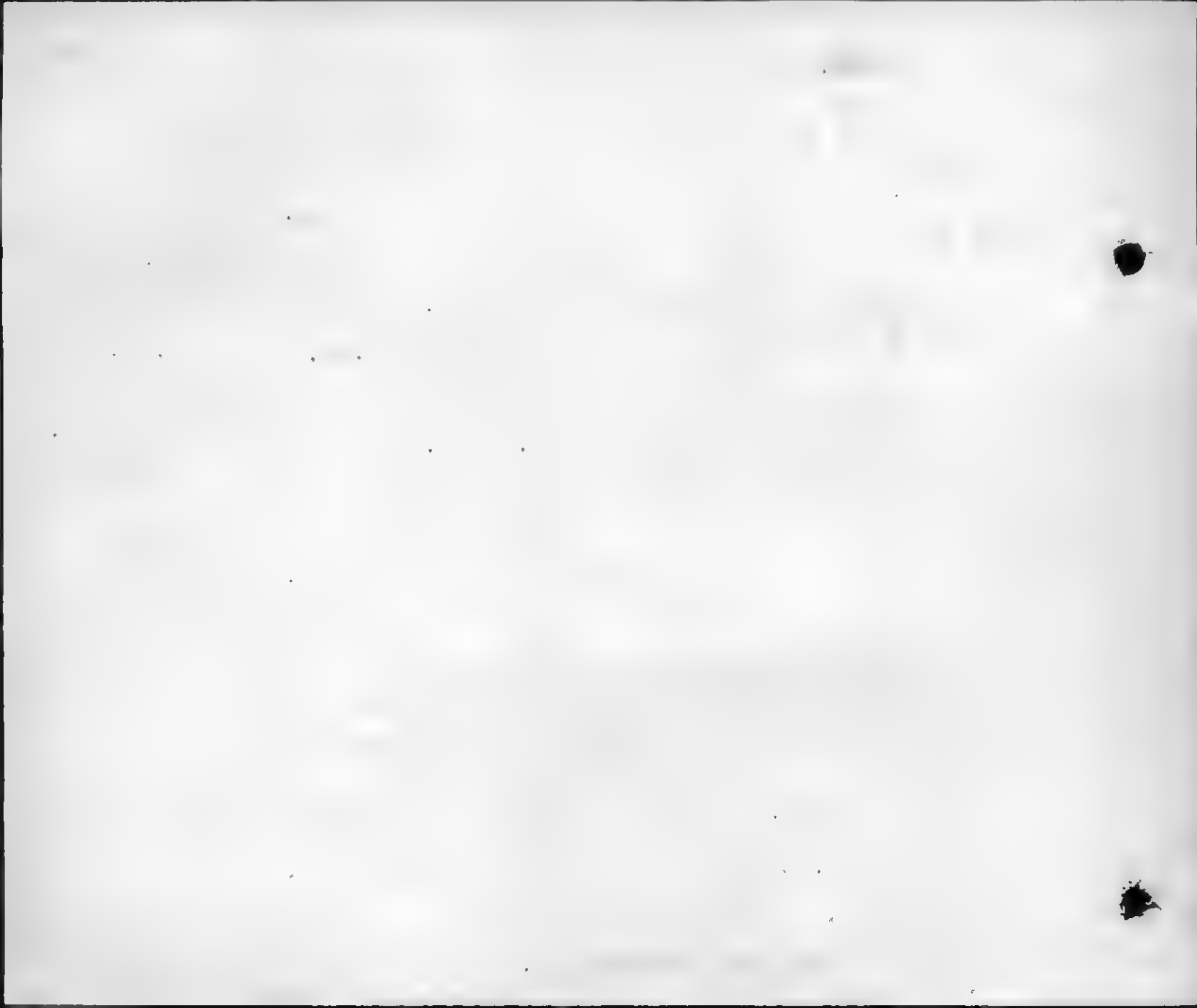
Reg. Dist. No.

11383

11369

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 124 South Seton Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 124 South Seton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Bell Last Havner		4. DATE OF DEATH Month October Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Keilholtz		14. MOTHER'S MAIDEN NAME Missouri Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. John J. Hollinger,		Address 124 South Seton Ave. Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) arricula fibrillation 5 years (c) arteriosclerotic C.V. disease several years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1960 to Oct 7, 1961 , that I last saw the deceased alive on Oct 7, 1961 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W R Cadle M.D.		ADDRESS (Street, city or town, state) Emmitsburg, Md. DATE SIGNED 10-9-61	
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle		Emmitsburg, Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 10, 1961	22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery	22d. LOCATION (City, town, or county) (State) Rockey Ridge, Frederick Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR Oct 10 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

C. E. Wilson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

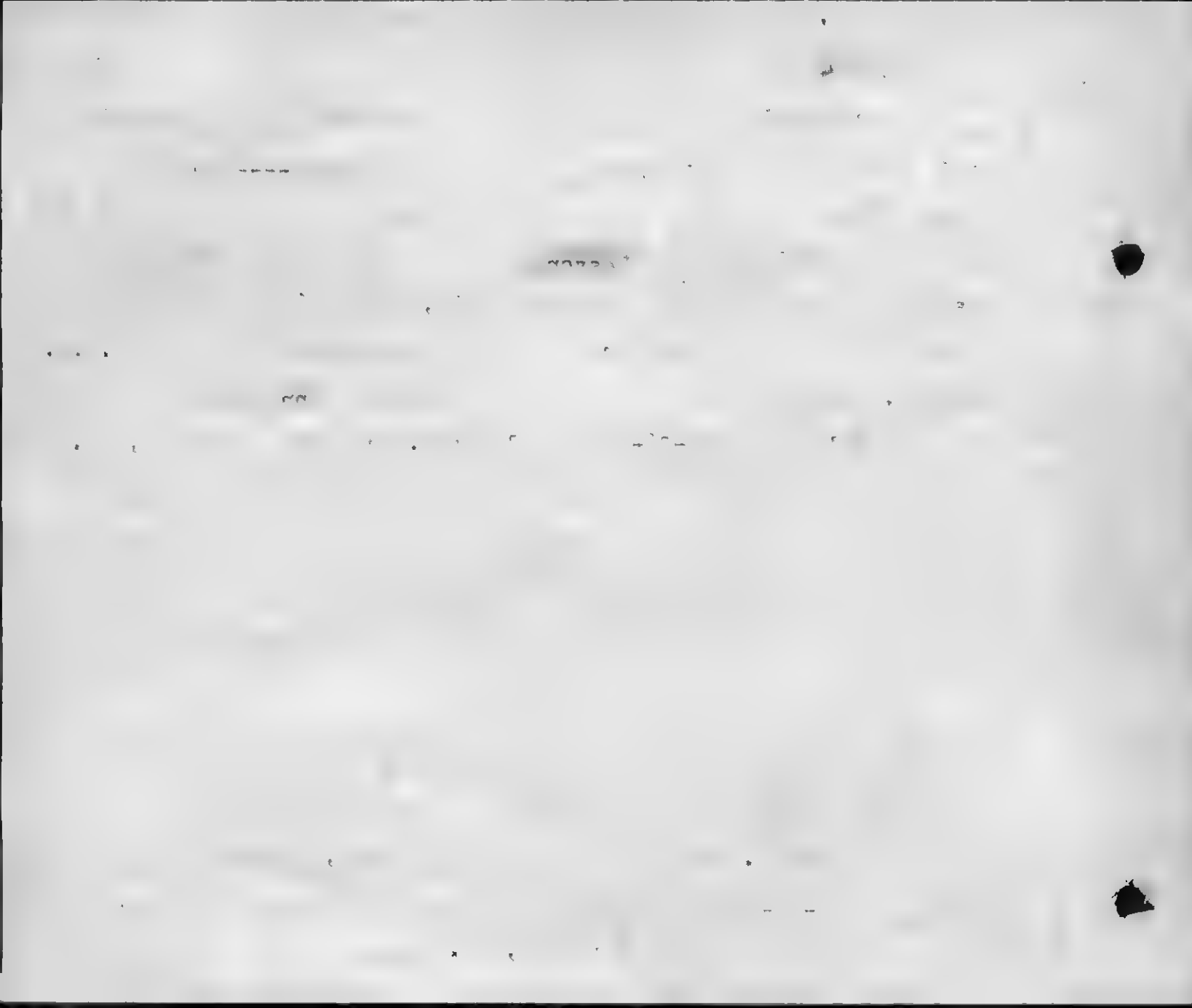
VR A15 (4)
15M 9/60

11384

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11370

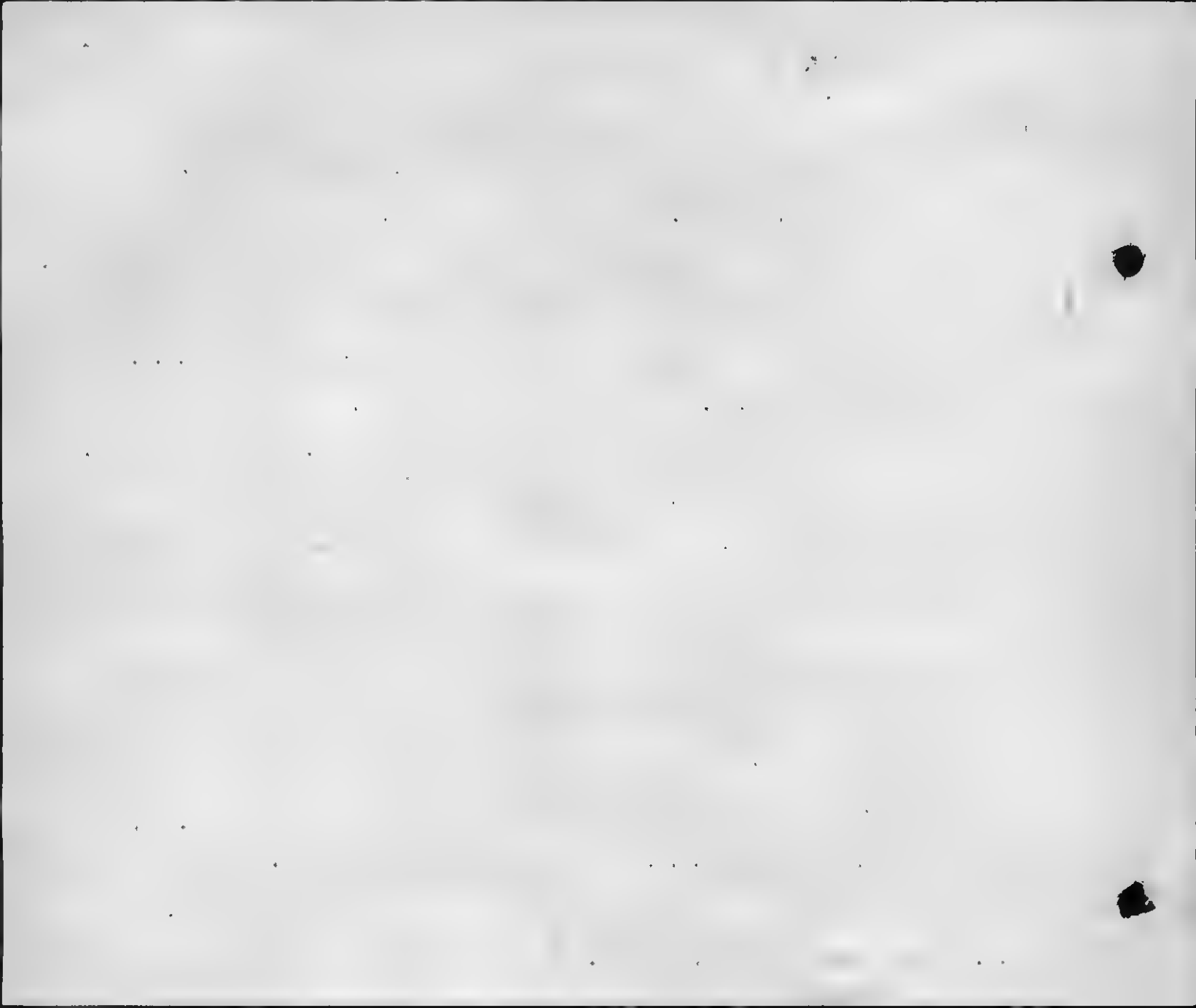
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Thurmont c. LENGTH OF STAY IN lb Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Own Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont d. STREET ADDRESS RD1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Gaver Hessong		4. DATE OF DEATH Month October Day 26 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John T. Hessong		14. MOTHER'S MAIDEN NAME Rebecca Ann Gaver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 215-36-6664		17. INFORMANT Gladys H. Hessong	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Arteriosclerotic type Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic and mitral Stenosis (c) Angina pectoris PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 years 4 yrs. 4 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Thurmont, Maryland	
21. I certify that (I) (this hospital) attended the deceased from Aug 1957 to Oct 26, 1961, that (I) (we) last saw the deceased alive on Oct 25, 1961, and that death occurred at 6:29 AM, from the causes and on the date stated above.					
22a. SIGNATURE James K. Gray		22b. DATE SIGNED 10-27-61			
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-61		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Gray		25a. REC'D BY REGISTRAR DATE OCT 30 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
11385														
11371														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville, Route #1 c. LENGTH OF STAY - IN Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knoxville, Maryland, route #1.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Frederick CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville, Maryland, route #1. d. STREET ADDRESS Knoxville, Maryland, route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) John Carlton Hope					4. DATE OF DEATH Month October Day 23 Year 19 61.									
5. SEX Male					6. COLOR OR RACE White					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH January 6, 1941					9. AGE (In years last birthday) 20 yrs.					10. IF UNDER 1 YEAR Months 23 Days 19 Hours 61.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer					12. KIND OF BUSINESS OR INDUSTRY Farming					13. BIRTHPLACE County & State, or foreign country Frederick County				
14. FATHER'S NAME John Alexander Hope, Sr.					15. MOTHER'S MAIDEN NAME Lillie Pearl.					16. CITIZEN OF WHAT COUNTRY? U.S.A.				
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					18. SOCIAL SECURITY NO. 214-42-1238					19. INFORMANT John Alexander Hope, Sr. Knoxville, route #1.				
20. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized metastasis of Lympho Sarcoma					21. INTERVAL BETWEEN ONSET AND DEATH 2 mo. 6 mo.?					22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										23. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					25a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					26. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				
27a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					28a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					29a. (City or town) Jefferson, Maryland.				
30a. (County)					31a. (State)					32. I certify that (I) (this hospital) attended the deceased from July 1961 to 10/23, 1961 , that (I) (we) last saw the deceased alive on 10/23, 1961 , and that death occurred at 7:10 PM from the causes and on the date stated above.				
21. SIGNATURE A. Talbott Brice M.D.					22. ADDRESS Jefferson, Maryland.					23. DATE SIGNED Oct. 25, 1961				
24. PHYSICIAN'S NAME (Type) A. Talbott Brice, M.D.					25. NAME OF CEMETERY OR CREMATORY Union Cemetery					26. LOCATION (City, town or county) Leesburg, Virginia.				
27. BURIAL, CREMATION, REMOVAL (Specify) Burial					28. DATE THEREOF 10/26/61					29. NAME OF CEMETERY OR CREMATORY Union Cemetery				
30. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland.					31. ADDRESS Frederick, Maryland.					32. DATE OCT 26 '61				
33. REGISTRAR'S SIGNATURE Charles L. Kraus					34. ADDRESS Frederick, Maryland.					35. DATE OCT 26 '61				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

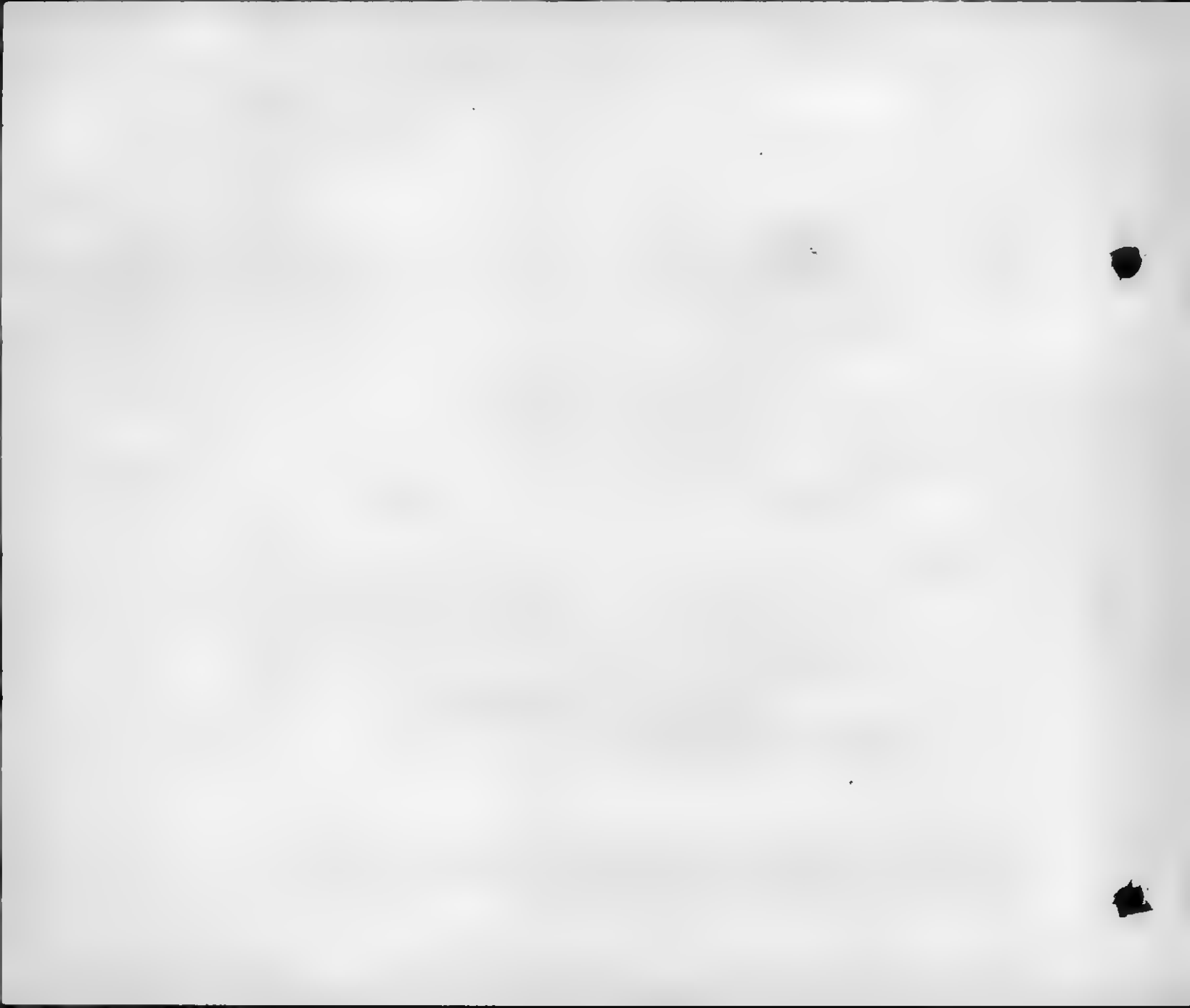
11386

CERTIFICATE OF DEATH

Reg. Dist. No.

11372

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODSBORO RURAL</u>	
c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>		d. STREET ADDRESS <u>1 CENTERVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA LEE HOUGH</u>		4. DATE OF DEATH Month Day Year <u>OCT. 5 19 61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 11 - 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB ALLISON</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE ALLISON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>SAMUEL W HOUGH WOODSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute collapse</u> <u>422.2</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 years</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>52</u> , to <u>October 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>61</u> , and that death occurred at <u>8:3</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>10-5-61</u>	
PHYSICIAN'S NAME (Type) <u>T.H. Legg, M.D.</u>		<u>Union Bridge, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT 8 - 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCKY HILL</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. H. Harpster & Sons Union Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



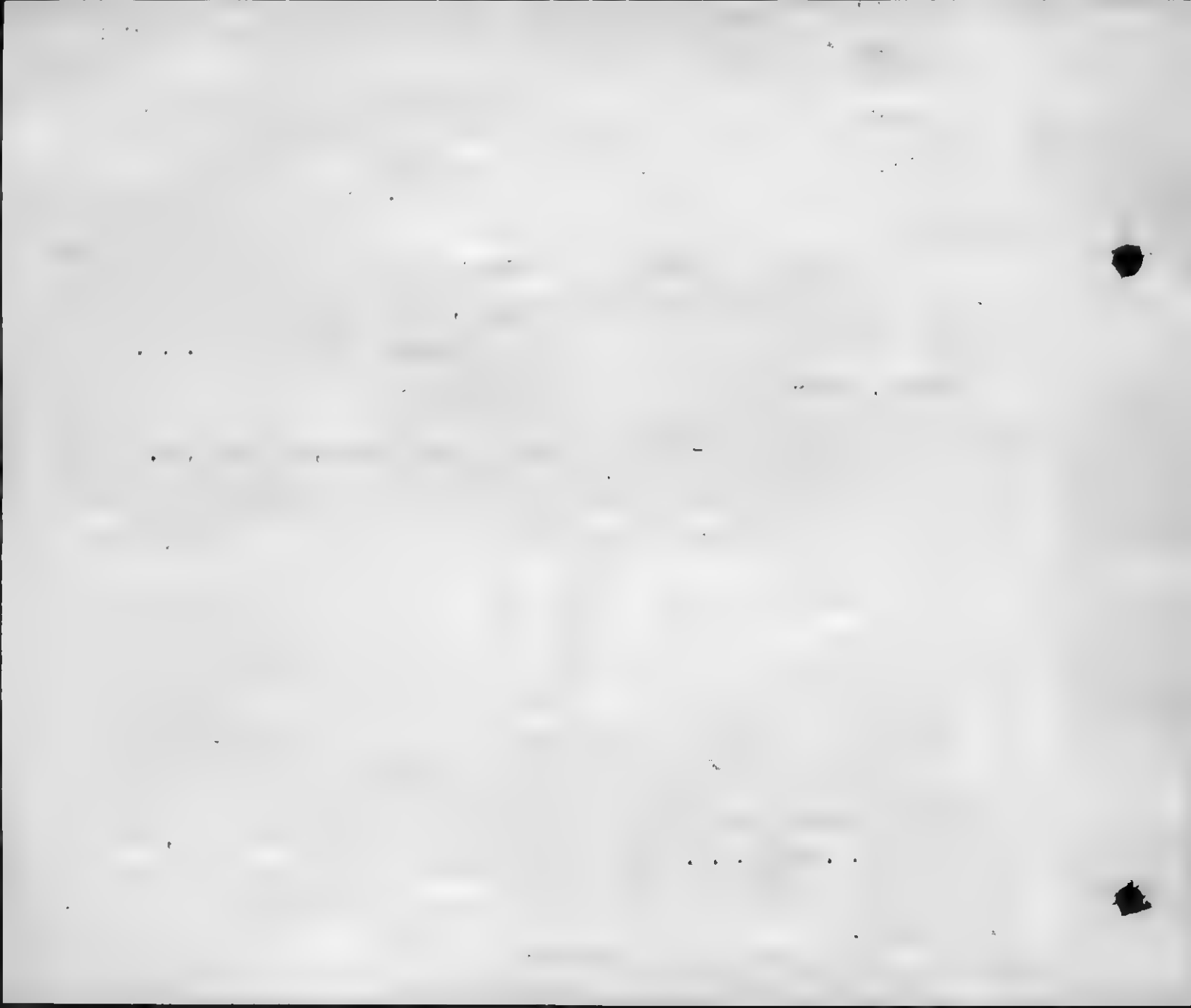
1
FOR STATE
HEALTH DEPT.

any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>11387</div> <div>11373</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>11387</div> <div>11373</div> </div> </div>															
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 43 East B. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Ernest McArthur Houser SEX Male COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				4. DATE OF DEATH October 22 1961 8. DATE OF BIRTH July 19, 1903 9. AGE (In years last birthday) 58 IF UNDER 1 YEAR: Months 5 Days 1 IF UNDER 24 HRS.: Hours 1 Min. 61				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Houser				14. MOTHER'S MAIDEN NAME Nora Moore				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 236-03-1547 17. INFORMANT Charles Harrington, Brunswick, Md. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Ch. Rheumatic H.D. (Antistreptococcal) DUE TO (c) 1 yr. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE B.O. Thomas EXAMINER'S NAME (Type) B.O. Thomas, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> October 23, 1961 Address (Street, city, town, or county)				DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10-24-1961				22c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW				22d. LOCATION (City, town, or county) (State) SHARPSBURG, MARYLAND			
23. FUNERAL DIRECTOR B. H. Lab				ADDRESS BRUNSWICK, MARYLAND				24a. REC'D BY REG. STRAR DATE OCT 26 '61				24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

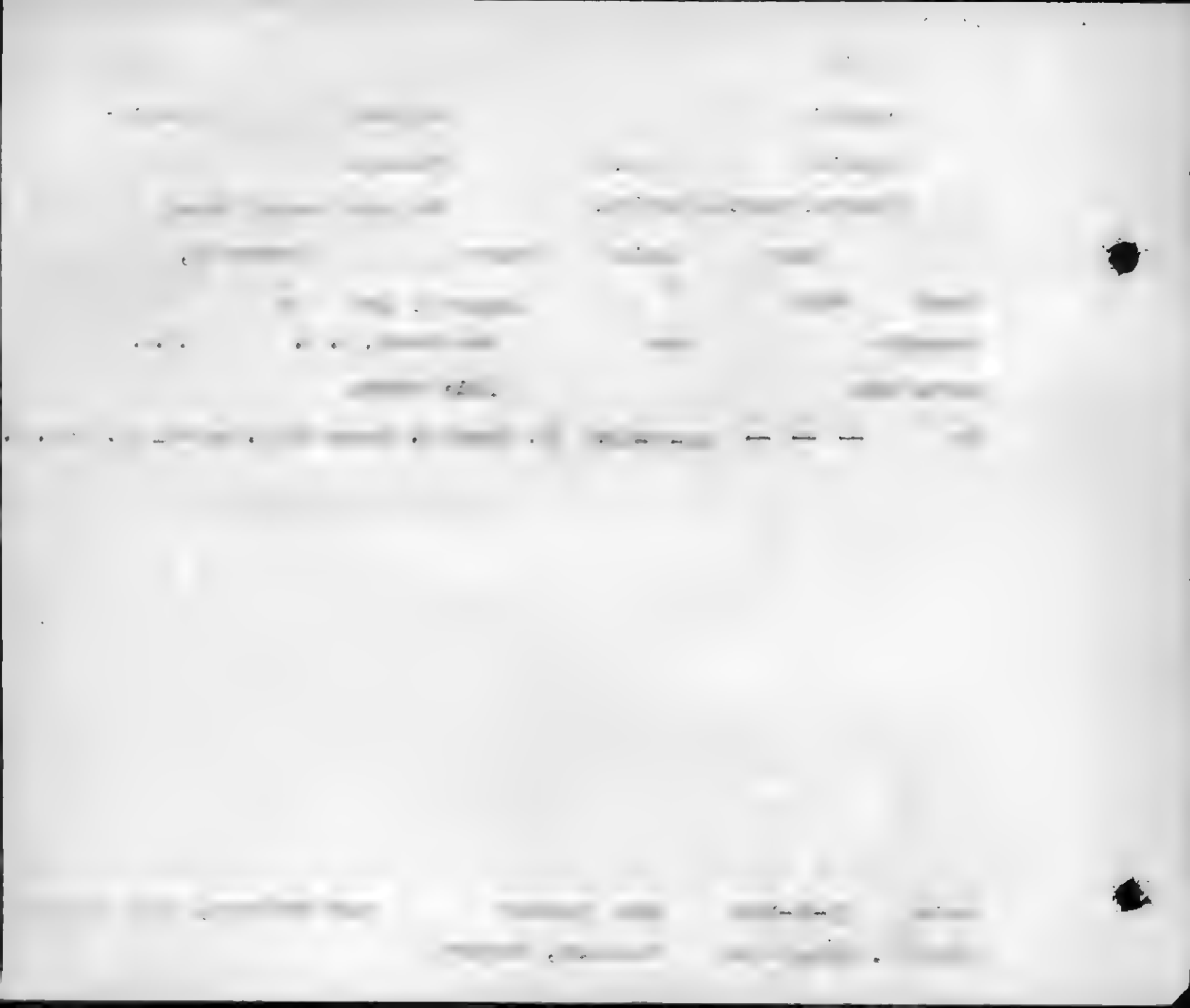


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARY LOUISE HOUSER										DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
11388										CERTIFICATE OF DEATH														
11374																								
1. PLACE OF DEATH a. COUNTY Frederick					b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick					c. LENGTH OF STAY IN 1b 1 year					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland					b. COUNTY Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Houser					4. DATE OF DEATH Month October Day 10 Year 19 61																			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 2, 1926		9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 35 Days 35 Hours 35 Min.		11. IF UNDER 24 HRS Months 35 Days 35 Hours 35 Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Ashe County, N. C.					12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Martin Ward					14. MOTHER'S MAIDEN NAME Alse Osborne																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO 408-38-0408					17. INFORMANT Mr. Ernest E. Houser Address 224 S. Carroll St. Fred. Md.														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis with primary presumption in the biliary system DUE TO (b) 8 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 DUE TO (c) 2										INTERVAL BETWEEN ONSET AND DEATH 8 weeks														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 8-18, 1961 , to 10-10, 1961 , that (I) (we) last saw the deceased alive on 10-10, 1961 , and that death occurred at M , from the causes and on the date stated above.																								
22a. SIGNATURE Rex R. Martin										22b. DATE SIGNED 10-10-61														
22c. PHYSICIAN'S NAME (Type) Rex R. Martin										22d. ADDRESS Frederick, Md.														
23a. BURIAL, CREMATION REMOVAL (Specify) Burial					23b. DATE THEREOF 10-11-1961					23c. NAME OF CEMETERY OR CREMATORY Ward Cemetery					23d. LOCATION (City, town, or county) (State) West Jefferson, North Carolina									
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son										25a. REC'D BY REGISTRAR Frederick, Maryland DATE OCT 16 '61										25b. REGISTRAR'S SIGNATURE 25b				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 File # 300
11389

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 11375

1. PLACE OF DEATH
a. COUNTY **Frederick**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Frederick**
c. LENGTH OF STAY IN 1b **40 Years**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **321 Queen Street**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland**
b. COUNTY **Frederick**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Frederick**
d. STREET ADDRESS **321 Queen Street**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **EVELYN** Middle **VIRGINIA** Last **HULL**

4. DATE OF DEATH
Month **October** Day **13** Year **19 61**

5. SEX **Female**

6. COLOR OR RACE **White**

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH **23 April 1921**

9. AGE (In years last birthday) **40** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **House-work**
10b. KIND OF BUSINESS OR INDUSTRY **At Home**
11. BIRTHPLACE (County & State, or foreign country) **Maryland**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Clayton C. Lenhart**
14. MOTHER'S MAIDEN NAME **Effie E. White**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**
16. SOCIAL SECURITY NO. **215-14-1570**
17. INFORMANT **Elmer A. Hull (Same as item #1)** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **581.0** DUE TO **Fatty metamorphosis of the liver with focal necrosis**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH **Day to weeks**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

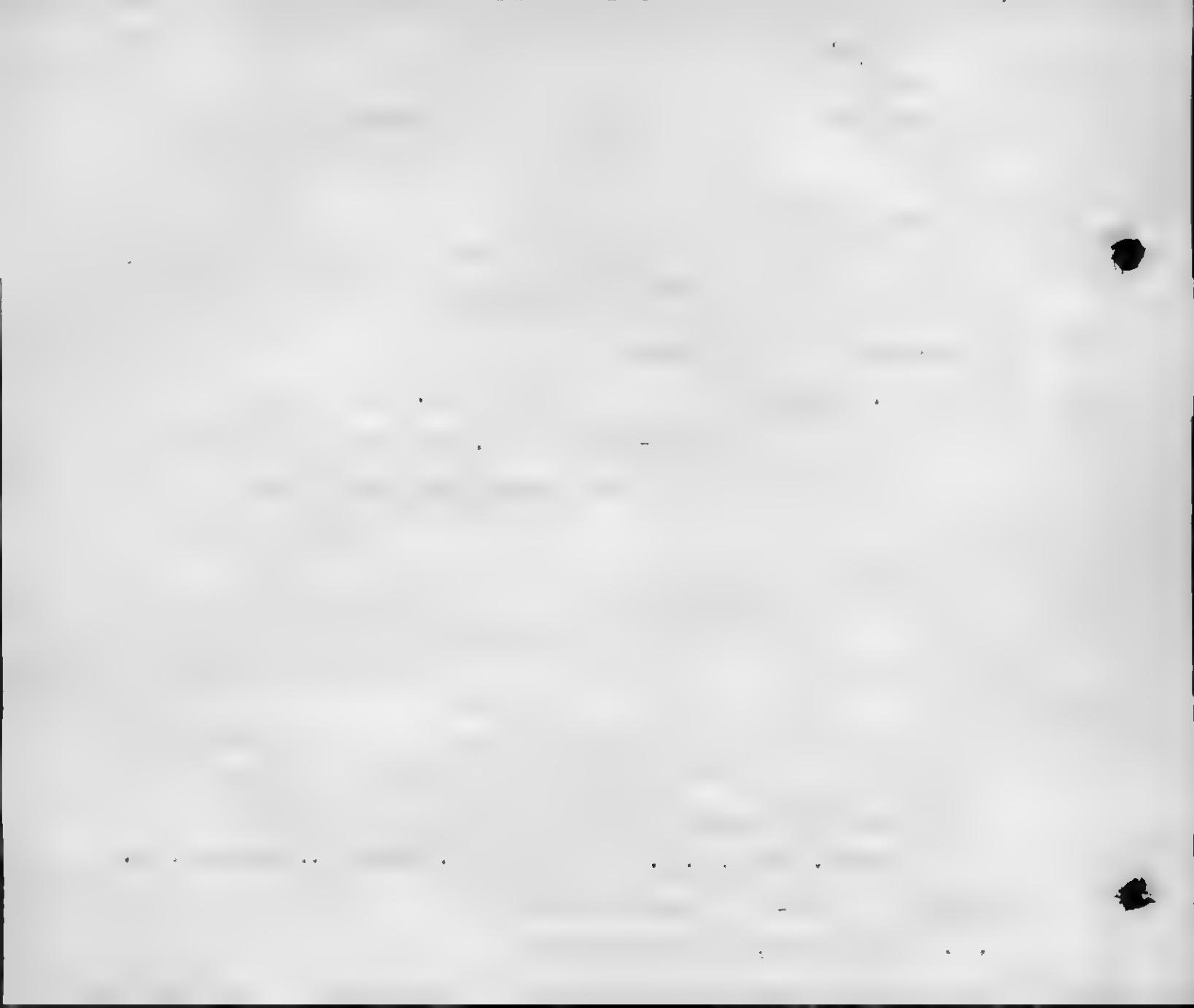
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **July** 19 **55** to **10-13-** 19**61**, that (I) (we) last saw the deceased alive on **10-10-1961**, and that death occurred at **8P** M. from the causes and on the date stated above.

22a. SIGNATURE **Rex R. Martin** M.D.
22b. DATE SIGNED **16 Oct 1961**
22c. PHYSICIAN'S NAME (Type) **Rex R. Martin, M. D.**
22d. ADDRESS **220 N. Market St., Frederick, Md.**

23a. BURIAL, CREMATION REMOVAL (Specify) **Burial**
23b. DATE THEREOF **10-17-61**
23c. NAME OF CEMETERY OR CREMATORY **Mount Olivet Cemetery**
23d. LOCATION (City, town or county) (State) **Frederick, Maryland**

24. FUNERAL DIRECTOR'S SIGNATURE **M. R. Etchison & Son, Frederick, Maryland** ADDRESS
25a. REC'D BY REGISTRAR **OCT 19 '61**
25b. REGISTRAR'S SIGNATURE **Arthur S. House**



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

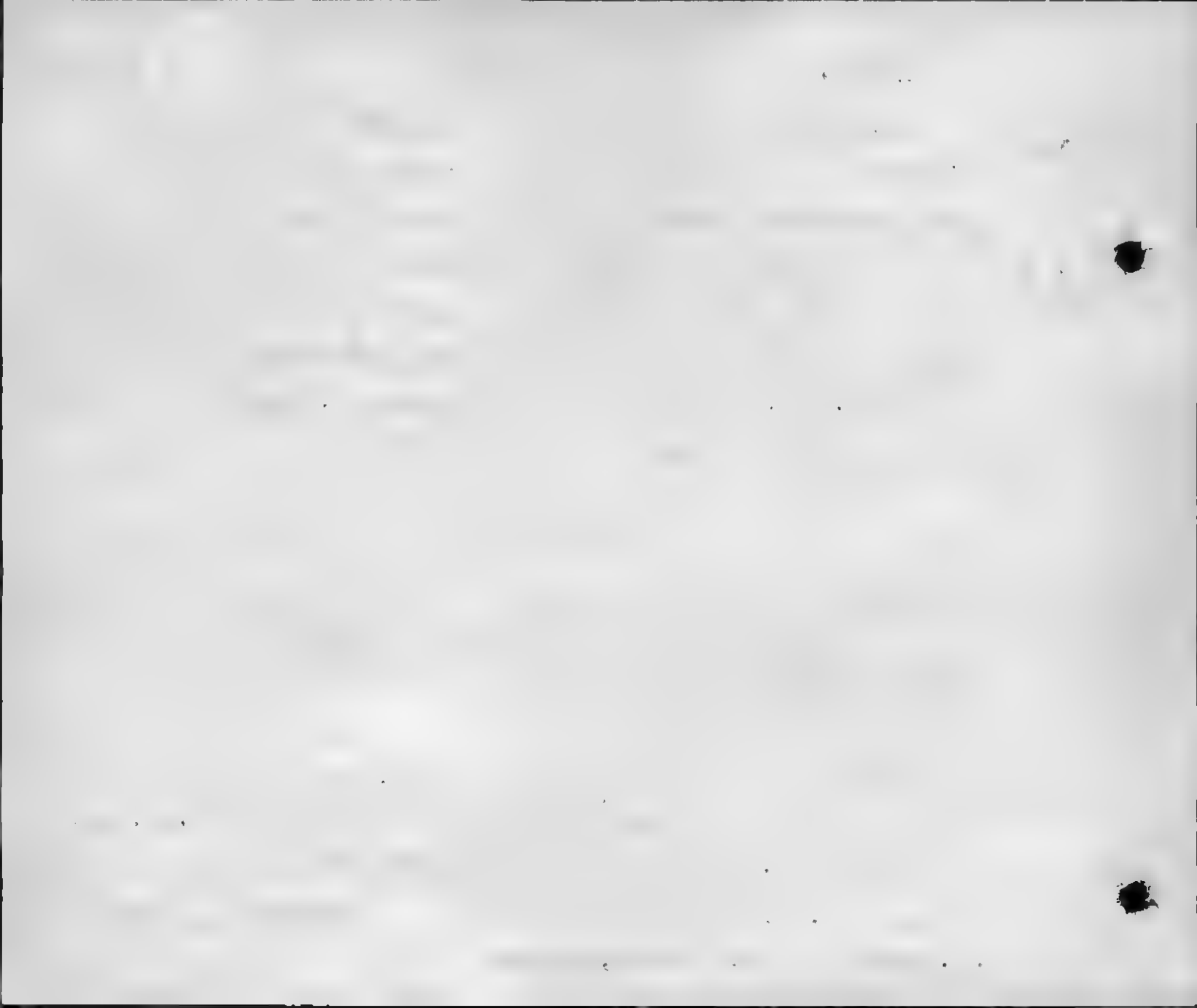
11390

11376

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Braddock Heights			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				e. STREET ADDRESS Maryland Avenue			
3. NAME OF DECEASED (Type or print) GEORGE LUTHER IFERT				4. DATE OF DEATH Month October Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> IFERT		8. DATE OF BIRTH Month March Day 13 Year 1872	
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua J. Ifert				14. MOTHER'S MAIDEN NAME Cleantha R. Coblentz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO None			
17. INFORMANT Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. 1 year			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pneumonia Bronchitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 4, 1958 , to Oct. 12, 1961 , that (I) (we) last saw the deceased alive on Oct. 12, 1961 , and that death occurred at 11:30 PM the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Stone M.D.				22b. DATE SIGNED Oct. 16, 1961			
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone MD				22d. ADDRESS 4 West 3rd Street, Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town or county) (State) Middletown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland				25a. REC'D BY REGISTRAR OCT 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

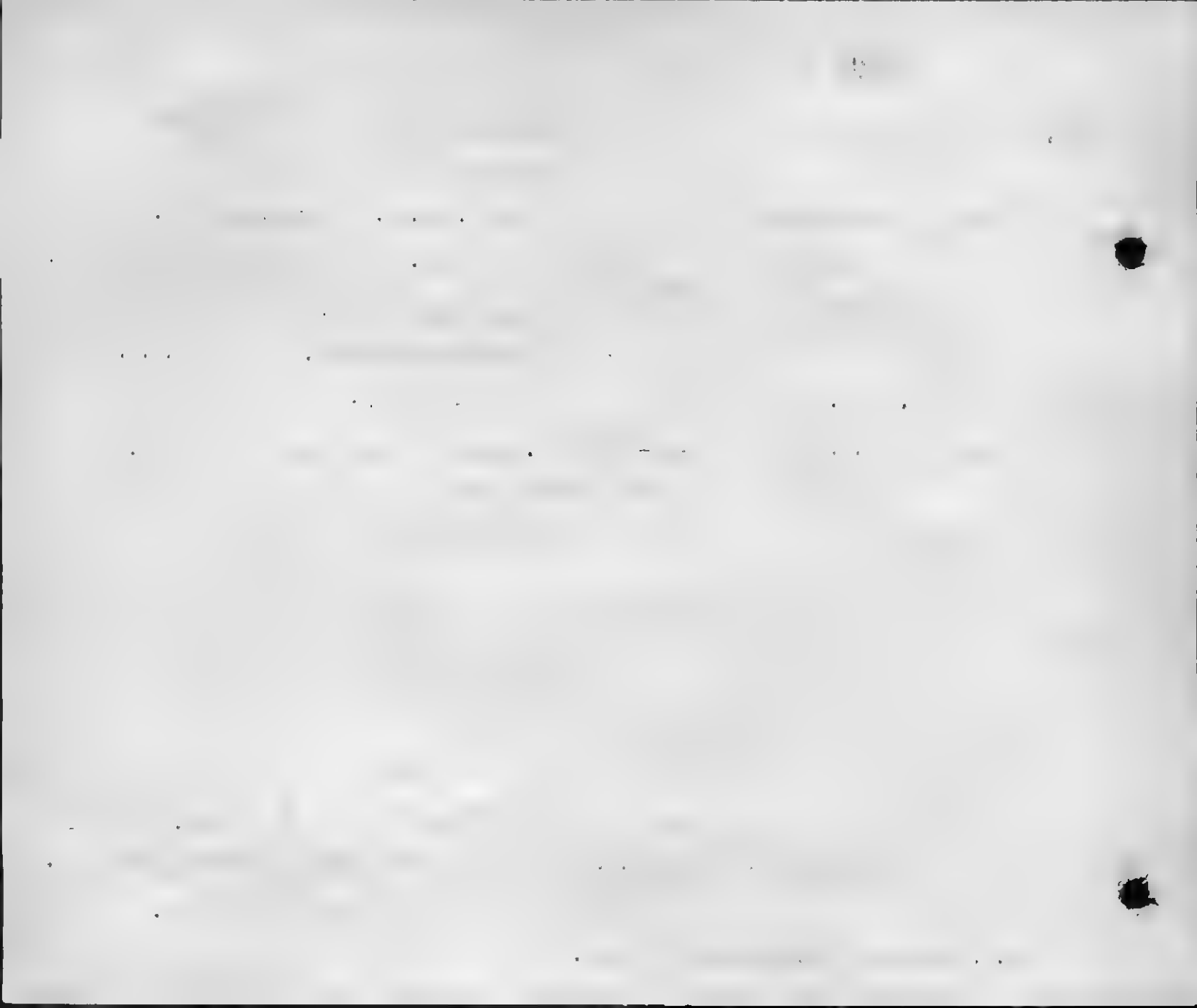


Arthur L. Hunt

1901 2

Chlorophyll

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CENTRAL STATE DEPARTMENT OF HEALTH

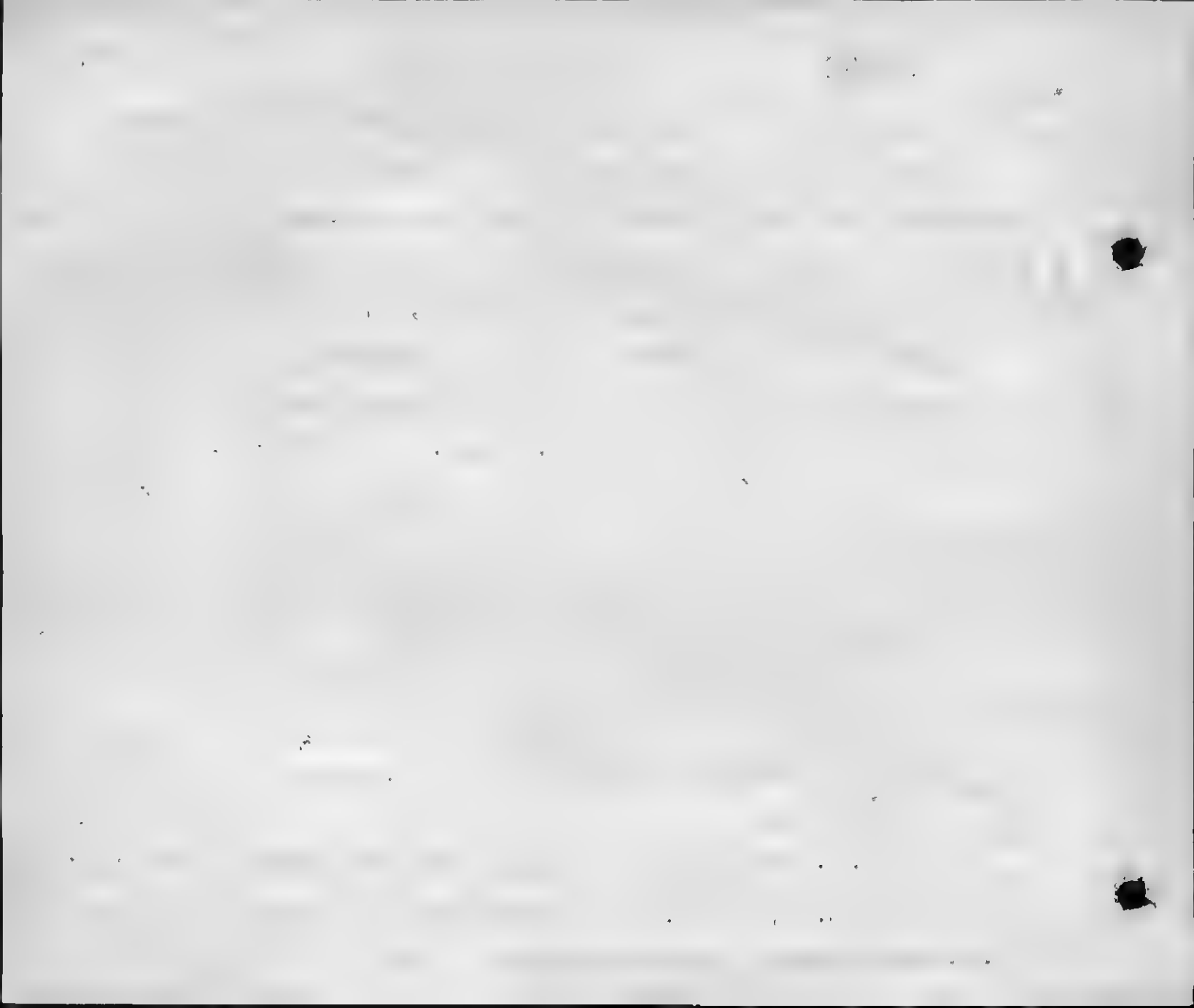
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11392

CERTIFICATE OF DEATH

11378

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick County Chronic Hospital		d. STREET ADDRESS 25 East South Street	
3. NAME OF DECEASED (Type or print) CLARA JEANETTE KOONTZ		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. DATE OF DEATH October 13 1961	
6. COLOR OR RACE White		7. DATE OF BIRTH December 15, 1870	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours M. n. 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
13. FATHER'S NAME John Bussard		14. MOTHER'S MAIDEN NAME Elizabeth Himes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right Eye X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cardio Vascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 84 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar 1954 to Oct 9 1961 , that (I) (we) last saw the deceased alive on Oct 9 1961 , and that death occurred 11:15 AM on the causes and on the date stated above.			
22a. SIGNATURE H. F. Kline		22b. DATE SIGNED October 16, 1961	
22c. PHYSICIAN'S NAME (Type) H. F. Kline MD		22d. ADDRESS 7 North Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial Oct. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		23d. LOCATION (City, town or county) (State) Jefferson Maryland	
25a. REC'D BY REGISTRAR OCT 18 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

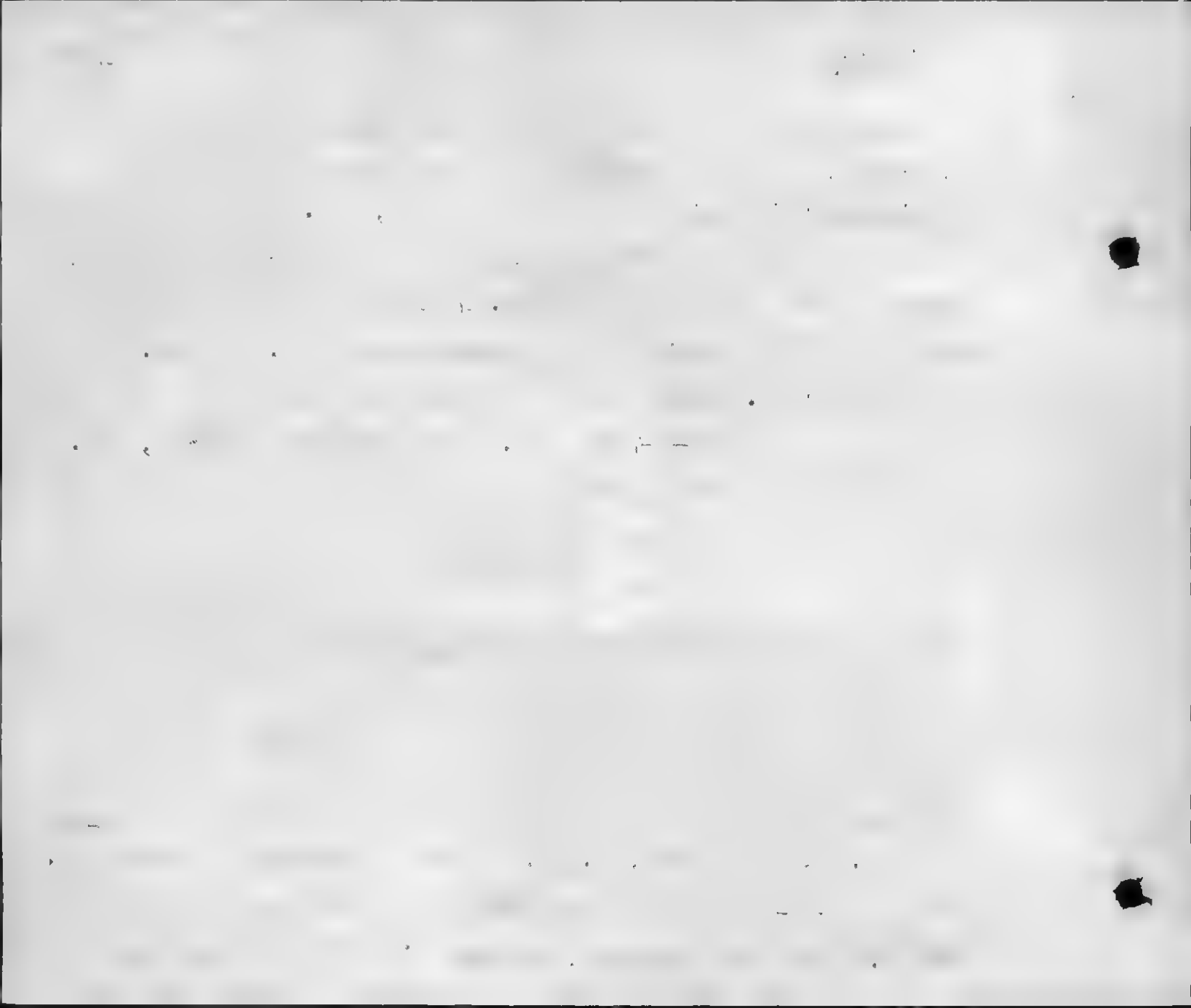
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11393

CERTIFICATE OF DEATH

11379

1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Frederick c. LENGTH OF STAY IN 1b lifetime		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Frederick d. STREET ADDRESS Frederick, Md.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH October 9 1961	
3. NAME OF DECEASED (Type or print) EMERY BURHAM LEASE		5. SEX Male 6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17 1874	
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10a. Farming		11. BIRTHPLACE (County & State, or foreign country) Frederick County Md.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Luther E. Lease	
14. MOTHER'S MAIDEN NAME Ascena Poole		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 215-36-7255		17. INFORMANT Mrs. Maurice Alexander Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Chronic Heart Failure DUE TO (c) Arterio-sclerotic heart dis.		INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 wks. 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congen. deformity thorax; Ch. pul. emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 Oct to 9 Oct , that (I) (we) last saw the deceased alive on 9 Oct , and that death occurred at 55-90 Oct M, from the causes and on the date stated above.		22a. SIGNATURE Charles H. Conley, Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10-10-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr. MD.		22d. ADDRESS 228 North Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-1961	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		25a. REC'D BY REGISTRAR OCT 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



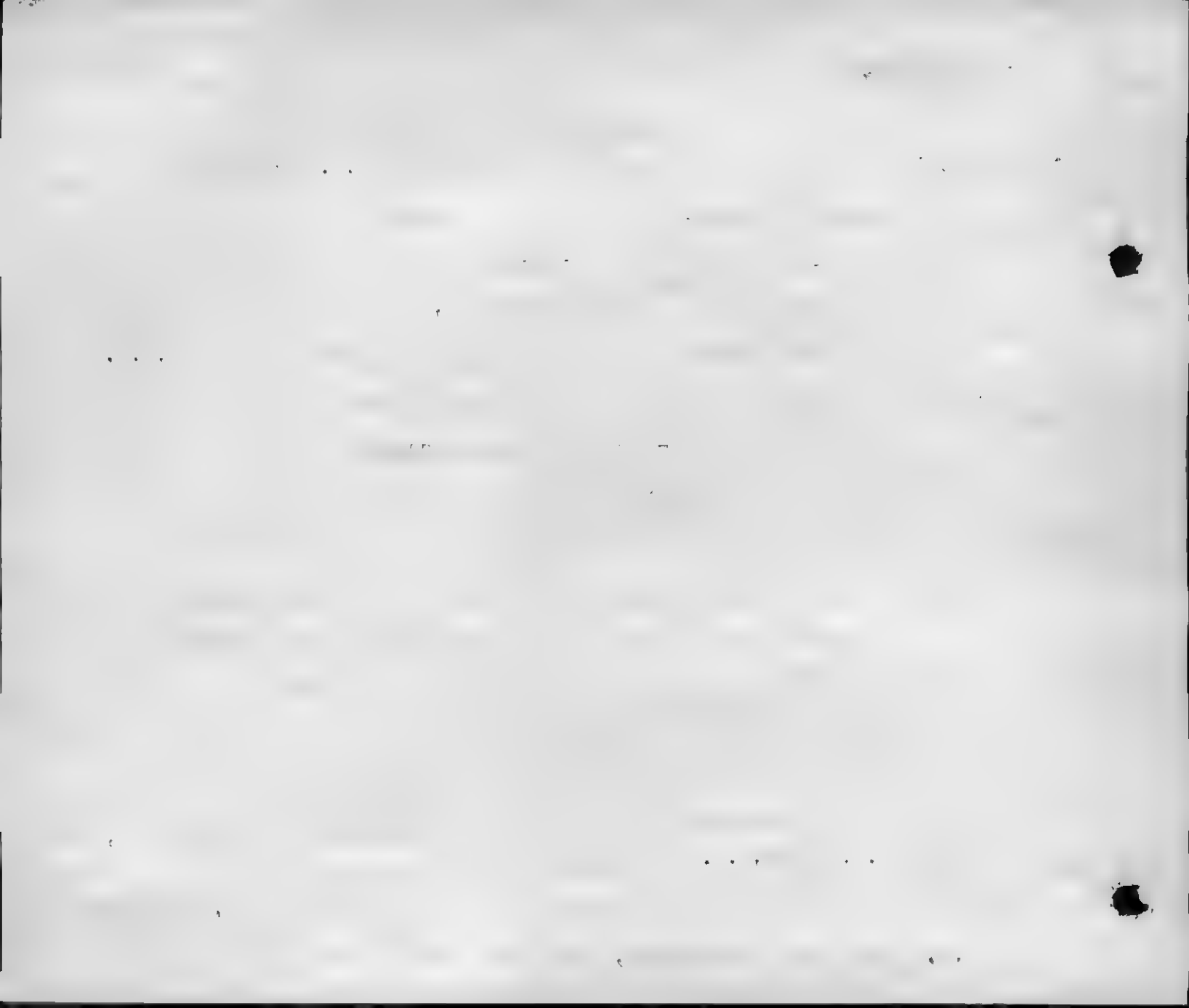
1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the delay should be explained in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Ijamsville R.D. (Centerville)		4. DATE OF DEATH Month October Day 12 Year 1961			
3. NAME OF DECEASED (Type or print) Earl Wilson Lyles		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1905		9. AGE (In years last birthday) 56 yrs.	
5. SEX Male		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer delivery truck		10b. KIND OF BUSINESS OR INDUSTRY Frederick County		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Lyles		14. MOTHER'S MAIDEN NAME Bessie Thompson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 210-14-1786		17. INFORMANT Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) This occurred during an operation for hernia, given cardiac message								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED October 13, 1961	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-61		22c. NAME OF CEMETERY OR CREMATORY Ebernezer		22d. LOCATION (City, town, or country) Frederick Co., Maryland		(State)	
23. FUNERAL DIRECTOR C.E. Hicks 111				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 17 '61		24b. REG. STR.'S SIGNATURE Colin L. K...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

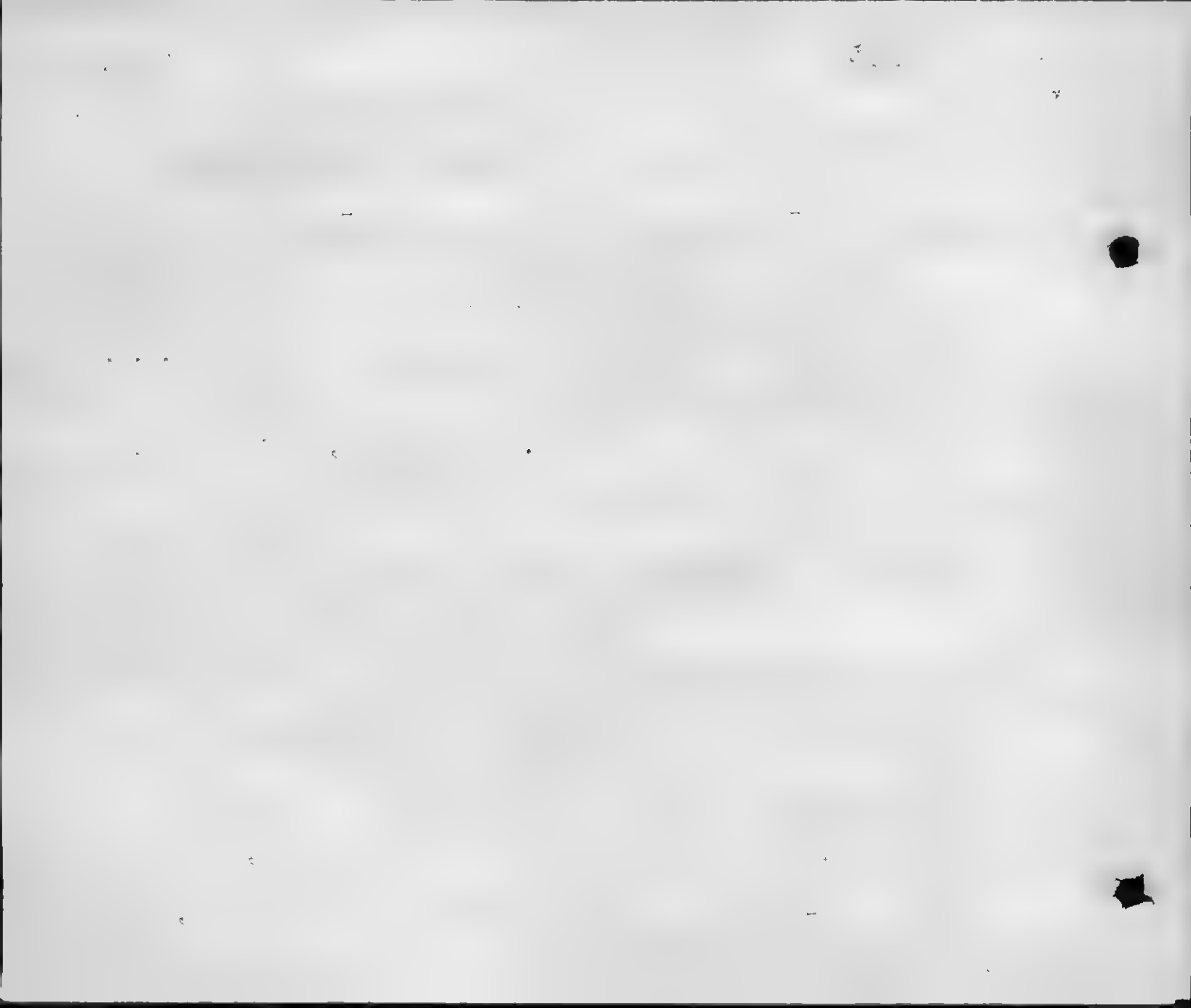
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11395

CERTIFICATE OF DEATH

11381

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broad Run (Burkittsville)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broad Run (Burkittsville)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Franklin Edward McDade		4. DATE OF DEATH Month 10 Day 9 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Utility		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas McDade		14. MOTHER'S MAIDEN NAME Ella Grams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Thomas McDade, Burkittsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO During Acute Asthmatic attack. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
21. I certify that (I) (this hospital) attended the deceased from Aug 9 1961 to Oct 9 1961 , that (I) (we) last saw the deceased alive on Oct 9 1961 , and that death occurred Oct 9 1961 , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE J. Elmer Harp		22b. DATE SIGNED Oct 10 1961	
22c. PHYSICIAN'S NAME (Type) J. Elmer Harp		22d. ADDRESS Middletown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-61	
23c. NAME OF CEMETERY OR CREMATORY Burkittsville		23d. LOCATION (City, town or county) (State) Burkittsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Gault		25a. REC'D BY REGISTRAR OCT 17 '61	
ADDRESS Brunswick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11396

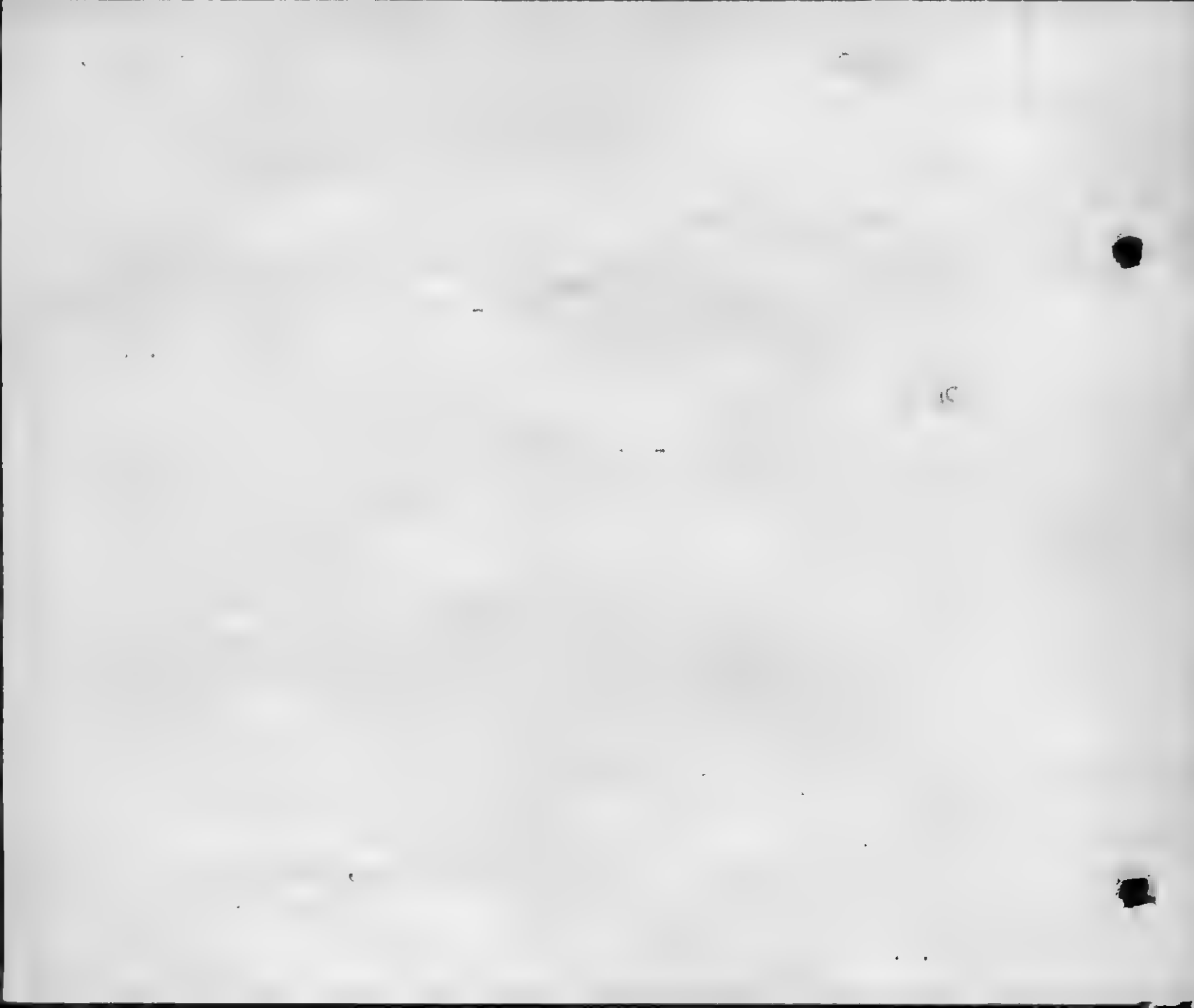
CERTIFICATE OF DEATH

11382

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sunnyside (rural)</u> c. LENGTH OF STAY IN 1b <u>54 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt 4 Frederick, Md</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick Co</u> d. STREET ADDRESS <u>Rt 4, Frederick</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Lutitia</u> <u>McKinney</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1961</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cannery worker</u>		9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>61</u> Min.		10. BIRTHPLACE (County & State or foreign country) <u>Carroll Co, Maryland</u> 11. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
12. FATHER'S NAME <u>John Poweary</u>		13. MOTHER'S MAIDEN NAME <u>Sarah Jobs</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 15. SOCIAL SECURITY NO. <u>220-01-5203</u> 16. INFORMANT <u>John McKinney</u> Address <u>Rt 4 Sunnyside, Fred.</u>			
17. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning Occlusion</u> (b) <u>Brain of Sclerosis & Latent</u> (c) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Hypertension</u>							
18. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Frederick</u>		20g. (County) <u>Frederick</u>		20h. (State) <u>Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1954</u> to <u>10/18, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> 19 <u>61</u> , and that death occurred at <u>10/18</u> M , from the causes and on the date stated above.							
22a. SIGNATURE <u>A.T. Brice</u>		22b. DATE SIGNED <u>10/17/61</u>		22c. PHYSICIAN'S NAME (Type) <u>A.T. BRICE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside</u>			
23d. LOCATION (City, town or county) <u>Frederick, Co</u>		23e. (State) <u>Md</u>		23f. (Country) <u>U.S.A</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs C.E. Hicks, Lll</u>		24a. ADDRESS <u>Frederick, Md</u>		25a. REC'D BY REGISTRAR <u>OCT 20 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>		25c. DATE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11397 Item 9 Film 6297 10/20/61 iwk 11383											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY	
Frederick		Frederick				88 years		Maryland		Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Monocacy Hall Nursing Home		Frederick									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month	
Zourie		Schroeder		Mobley		October		13, 1961		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		November 5, 1873		68 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Homemaker		none		Frederick, Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
George A. Schroeder		Mary Alice Wolf									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		Address					
No				Mrs. Mary Alice Markey		201 Grove Blvd. Fred. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized carcinomatosis									
DUE TO		3 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Carcinoma, caecum									
DUE TO		6 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
19											
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961, to Oct. 13, 1961, that (I) (we) last saw the deceased alive on Oct. 12, 1961, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS.		22b. DATE SIGNED	
B. O. Thomas Jr.										10-13-1961	
22c. PHYSICIAN'S NAME (Type)		M.D.		22d. ADDRESS							
Dr. B. O. Thomas, Jr.				228 North Market Street Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		10-16-1961		Frederick Memorial Park		Frederick, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E. Dailey & Son		Frederick, Maryland		DATE OCT 17 '61		Arthur S. Thomas					

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

2000

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11398

11384

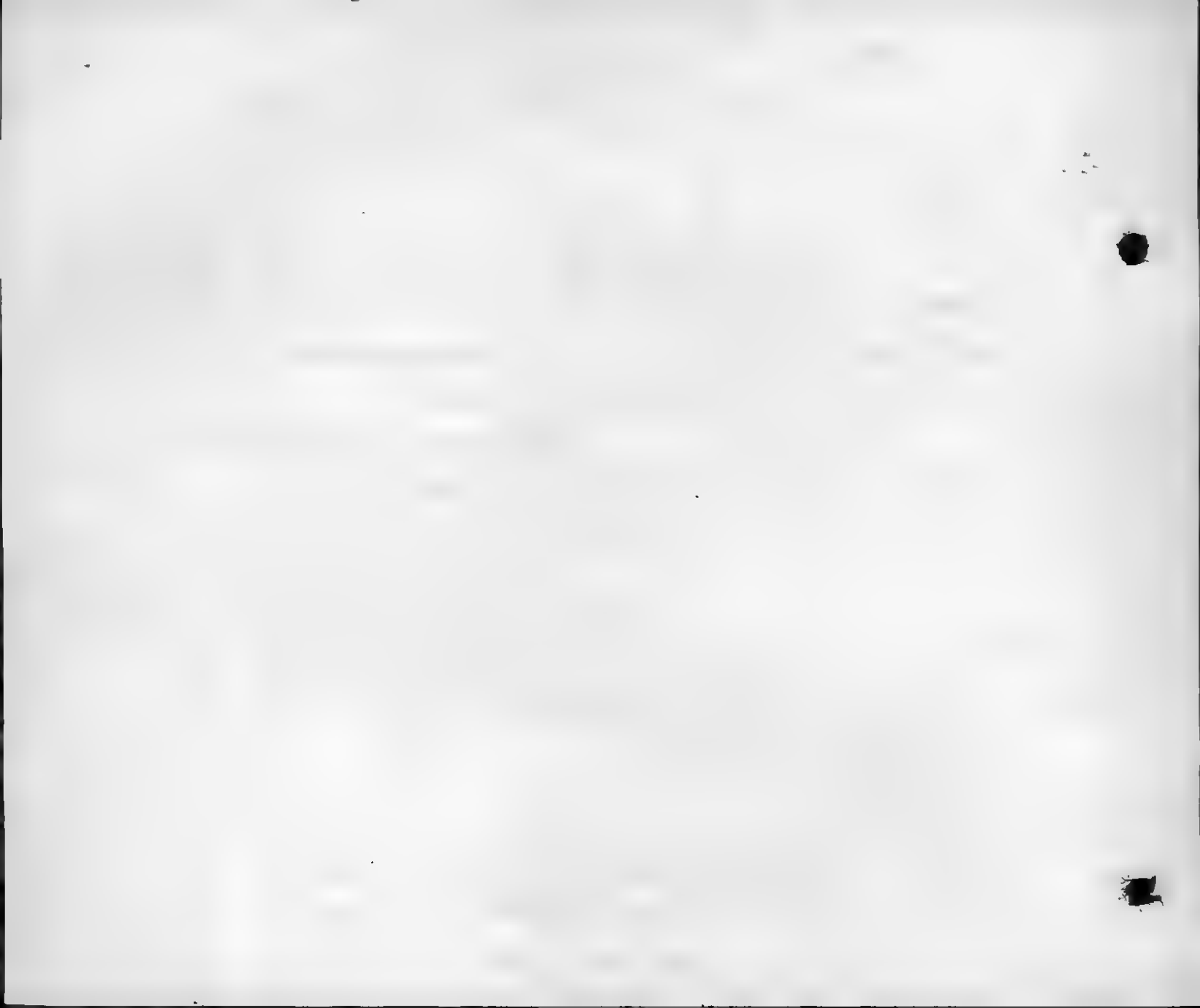
Item 14 Film G298

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK CITY HOSP.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME DECEASED (Type or print) First DANIEL Middle M. Last NORRIS				4. DATE OF DEATH Month OCTOBER Day 21 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1883	9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William NORRIS				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS CHAS. STOWE 4005 Deepwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC DUE TO (c) CARDIOVASCULAR DISEASE							INTERVAL BETWEEN ONSET AND DEATH 12 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10/20 19 61 , to 10/21 19 61 , that (1) (we) last saw the deceased alive on 10/20 19 61 , and that death occurred at 2:20 AM, from the causes and on the date stated above.							
22a. SIGNATURE Richard C. Reynolds				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 9 EAST CHURCH ST. FREDERICK, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		10/23/61		BALTIMORE		BALTIMORE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck				ADDRESS 5305 HARFORD RD.		25a. REC'D BY REGISTRAR DATE 24 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

I

O

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11399

CERTIFICATE OF DEATH

Item 14 from Gary 11/3/61

11385

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Emmitsburg

c. LENGTH OF STAY IN b

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Md

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Emmitsburg

d. STREET ADDRESS

e. IS RESIDENCE ON FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Thomas Joseph Norris

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

April 20. 1878

4. DATE OF DEATH

Month

Day

Year

Oct. 25. 1961

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Professor

10b. KIND OF BUSINESS OR INDUSTRY

Mt. St. Marys College-Ireland Tipperary Co. U.S.A

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Norris

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-30-5759

17. INFORMANT

Lumen F. Norris Emmitsburg Md

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

1201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

Coronary occlusion
arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

30 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1958 to Oct 25, 1961, that (I) (we) last saw the deceased alive on Oct 24, 1961, and that death occurred on Oct 25, 1961, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

George L. Morningstar

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

S. Seton St. Emmitsburg MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Oct. 27. 1961

23c. NAME OF CEMETERY OR CREMATORY

St. Anthony Cem.

23d. LOCATION (City, town or county)

Emmitsburg R.D. MD

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

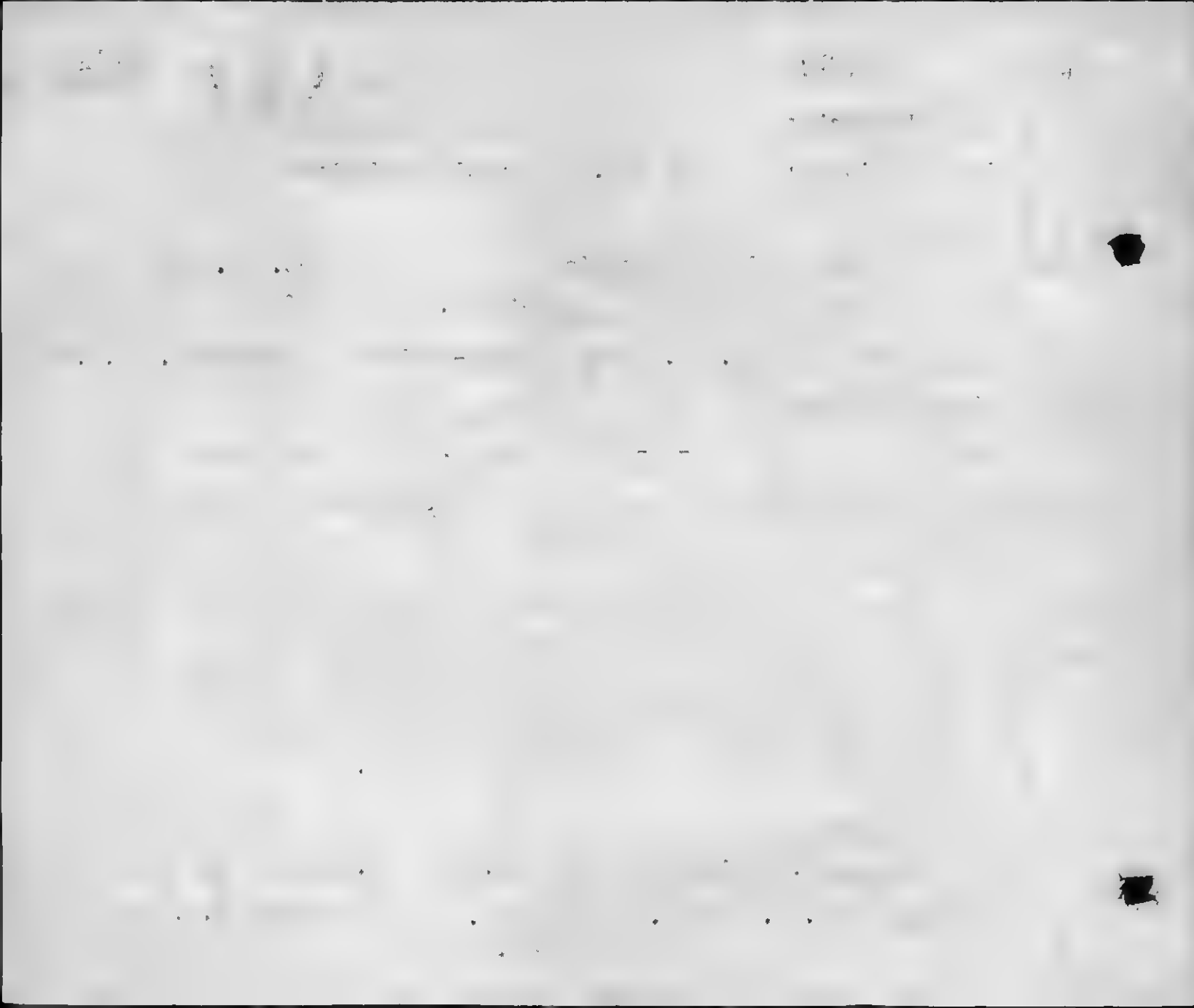
Thurmont. Md

25a. REC'D BY REGISTRAR

DATE OCT 31 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Hines



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11386

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>195 Perma Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>CURTIS</u> First <u>OMER</u> Middle <u>OTEX</u> Last		4. DATE OF DEATH Month <u>OCT.</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Job Printing Co. Woodlawn, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.-9.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Linwood C. Otey</u>		14. MOTHER'S MAIDEN NAME <u>Sarah King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-05-2889</u>	
17. INFORMANT <u>Mrs. Mary U. Otey</u> Address <u>same address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive aspiration pneumonia</u> 111X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> 19 <u>61</u> to <u>10/13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>10/13</u> 19 <u>61</u> , and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas D. Michael</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thomas D. Michael</u>		22d. ADDRESS <u>Frederick, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 18, 61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr.</u>		25a. REC'D BY REGISTRAR <u>Oct 19 '61</u>	
ADDRESS <u>Westminster, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Smith</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11401

11387

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

2 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

21A West All Saints St

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE

Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. STREET ADDRESS

21A West All Saints St

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

Mary

Ambush

Price

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

5-10-1901

9. AGE (In years last birthday)

60 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

hotel maid

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Earnest Ambush

14. MOTHER'S MAIDEN NAME

Johnnie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

--- No ---

16. SOCIAL SECURITY NO.

UNKNOWN

17. INFORMANT

Annie Naylor 156 Saints St Frederick

INTERVAL BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Sudden Death - Probable Coronary Thrombosis

minutes

Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.

HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

4+ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)

Rheumatoid Arthritis; Spastic PARAPLEGIA, mild.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. p.m. 19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 9/21, 1961, to 10/11, 1961, that (I) (we) last saw the deceased alive on 10/12, 1961, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Richard C. Reynolds, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

10/12/61

22c. PHYSICIAN'S NAME (Type)

RICHARD C. REYNOLDS, M.D.

22d. ADDRESS

9 EAST CHURCH ST. FREDERICK, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

10-14-61

23c. NAME OF CEMETERY OR CREMATORY

St Pauls

23d. LOCATION (City, town or county)

Della, Frederick Co., Md

24. FUNERAL DIRECTOR'S SIGNATURE

Hicks Funeral Home

ADDRESS

Frederick, Md

25a. REC'D BY REGISTRAR

OCT 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
15M 9/60



CERTIFICATE OF DEATH

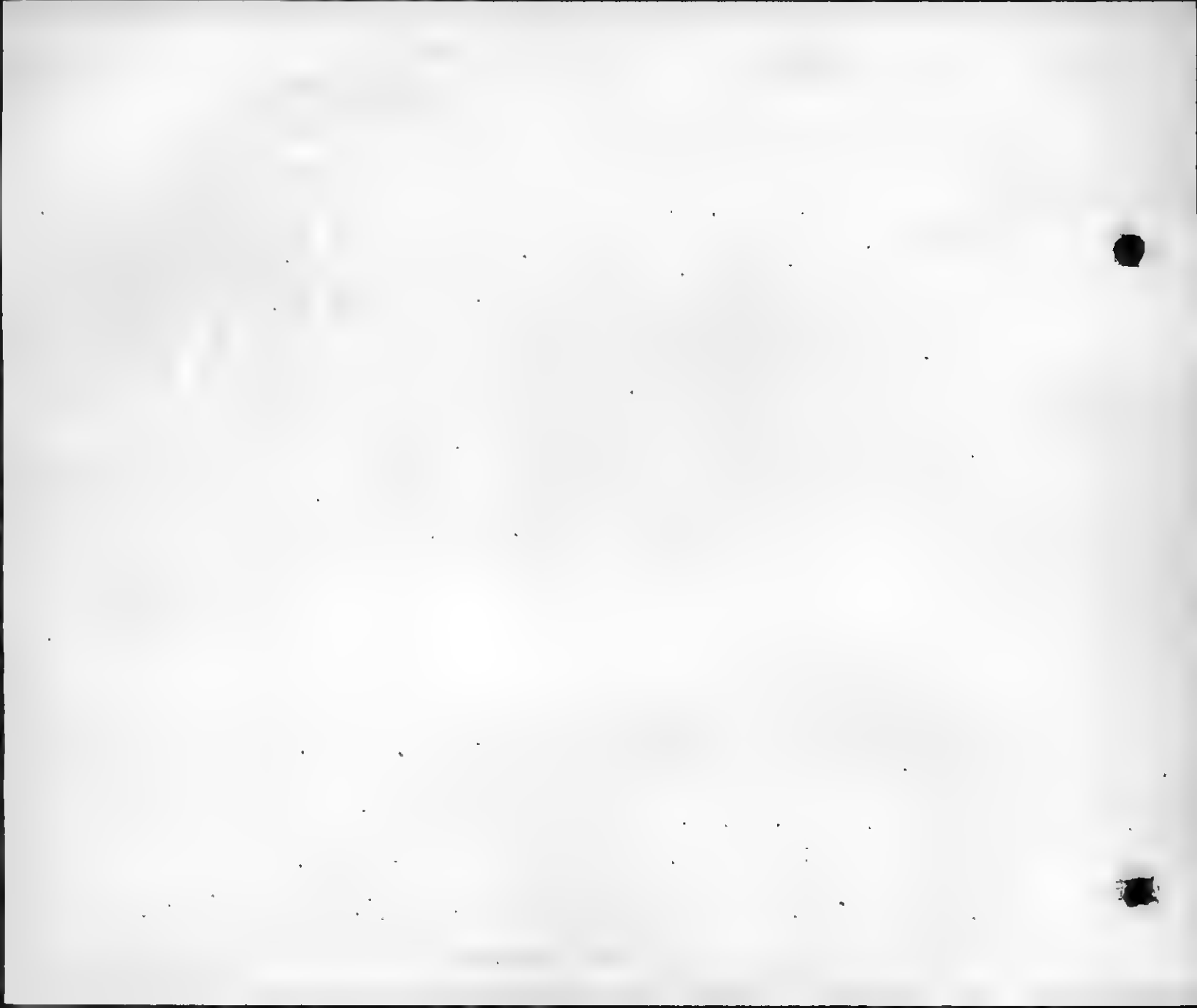
Reg. Dist. No. 11388

11402

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>06x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>En Route to Hospital in Ambulance</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin Franklin Rigler</u>		4. DATE OF DEATH Month Day Year <u>October 12 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George Washington Rigler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Elgin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs. Hattie Rigler, Mt. Airy, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>10 years</u> (c) <u>1 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>—</u> , 19 <u>55</u> , to <u>October</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>October 12</u> , 19 <u>61</u> , and that death occurred at <u>5 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>900 So. Main St. Mt. Airy, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>10/13/61</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-15-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz, Winfield Maryland</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 17 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

1

11403

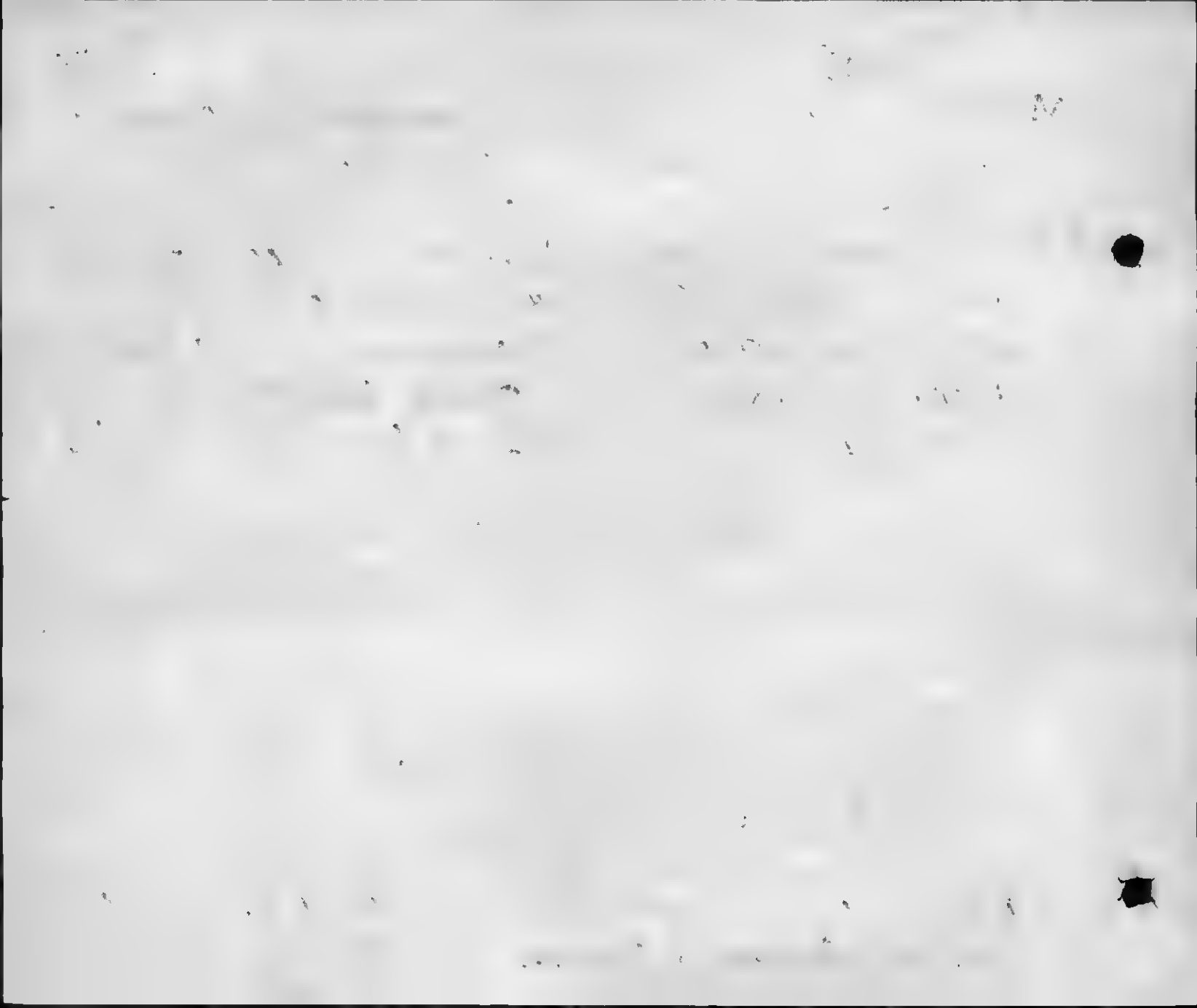
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11389

1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRUNSWICK c. LENGTH OF STAY IN 1b 65 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 220 A STREET		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRUNSWICK d. STREET ADDRESS 220 A STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES HENRY RINKER		4. DATE OF DEATH Month 10 Day 29 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1896
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 10 Days 29 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRINTER & PUBLISHER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME KIRBY J. RINKER	
14. MOTHER'S MAIDEN NAME FANNIE WENNER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? WORLD WAR I	
16. SOCIAL SECURITY NO. 10-29-1961		17. INFORMANT Address MRS LOVELLA RINKER, BRUNSWICK, MD	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY G.C.C. LESION Conditions, if any, which gave rise to immediate cause (b) HYPERTENSION C-V-R disease (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 10 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-29-1961 to 10-29-1961 that (I) (we) last saw the deceased alive on 10-29-1961 , and that death occurred at 10-29-1961 AM, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10-30-61	
22c. PHYSICIAN'S NAME (Type) C. E. PRIVITY		22d. ADDRESS BRUNSWICK, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-1-61	
23c. NAME OF CEMETERY OR CREMATORY CHURCH OF GOD		23d. LOCATION (City, town or county) (State) LOCUST VALLEY MD.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS BRUNSWICK, MARYLAND		25a. REC'D BY REGISTRAR NOV 3 1961 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11390

11404

PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE

Maryland

b. COUNTY

Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural--Mt. Airy

c. LENGTH OF STAY IN 1b

11 Yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural--Mt. Airy

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

R. D. # 4

d. STREET ADDRESS

R. D. # 4

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☐

3. NAME OF DECEASED
(Type or print)

HARVEY

F.

RIPPEON

4. DATE OF DEATH

October

17,

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug. 7, 1897

9. AGE (In years last birthday)

64

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Z. Rippeon

14. MOTHER'S MAIDEN NAME

Ida M. Zimmerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

220-16-4153

17. INFORMANT

Address

Mrs. Hilda E. Rippeon, Same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Tumor (Malignant)

INTERVAL BETWEEN ONSET AND DEATH

1930

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Sept 16, 1961, to Oct 17, 1961, that I last saw the deceased alive on Oct 16, 1961, and that death occurred at 6 a. m. from the causes and on the date stated above.

ACTUAL SIGNATURE

C. M. Van Poole

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

10-17-61

PHYSICIAN'S NAME (Type)

C. M. Van Poole, M. D.

Mt. Airy, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-20-1961

22c. NAME OF CEMETERY OR CREMATORY

Locust Grove Cemetery Frederick Co., Maryland

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

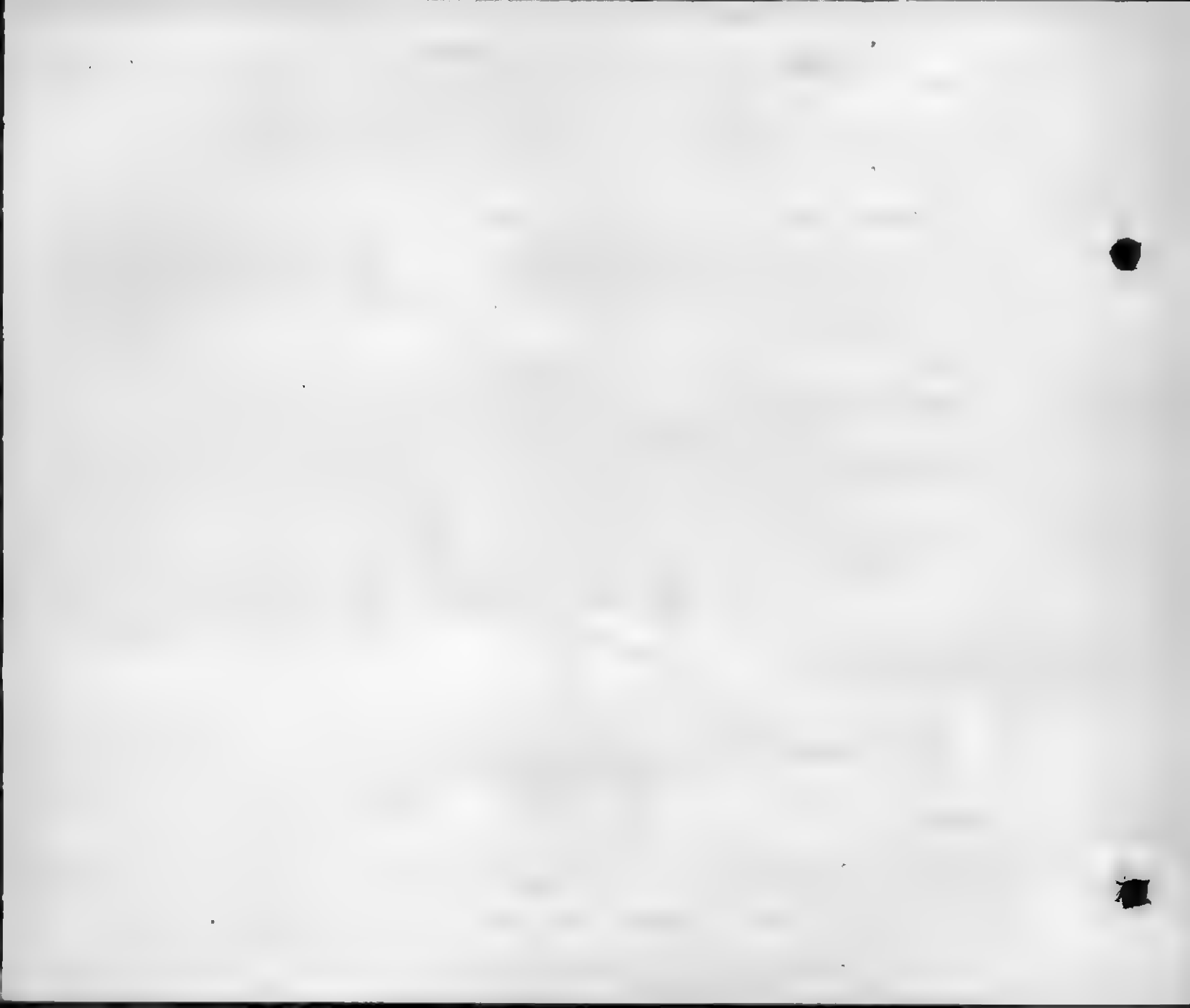
C. M. Waltz, Winfield, Maryland

24a. REC'D BY REGISTRAR

DATE OCT 18 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Haines



my remains retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11405

11391

1

4

M

X

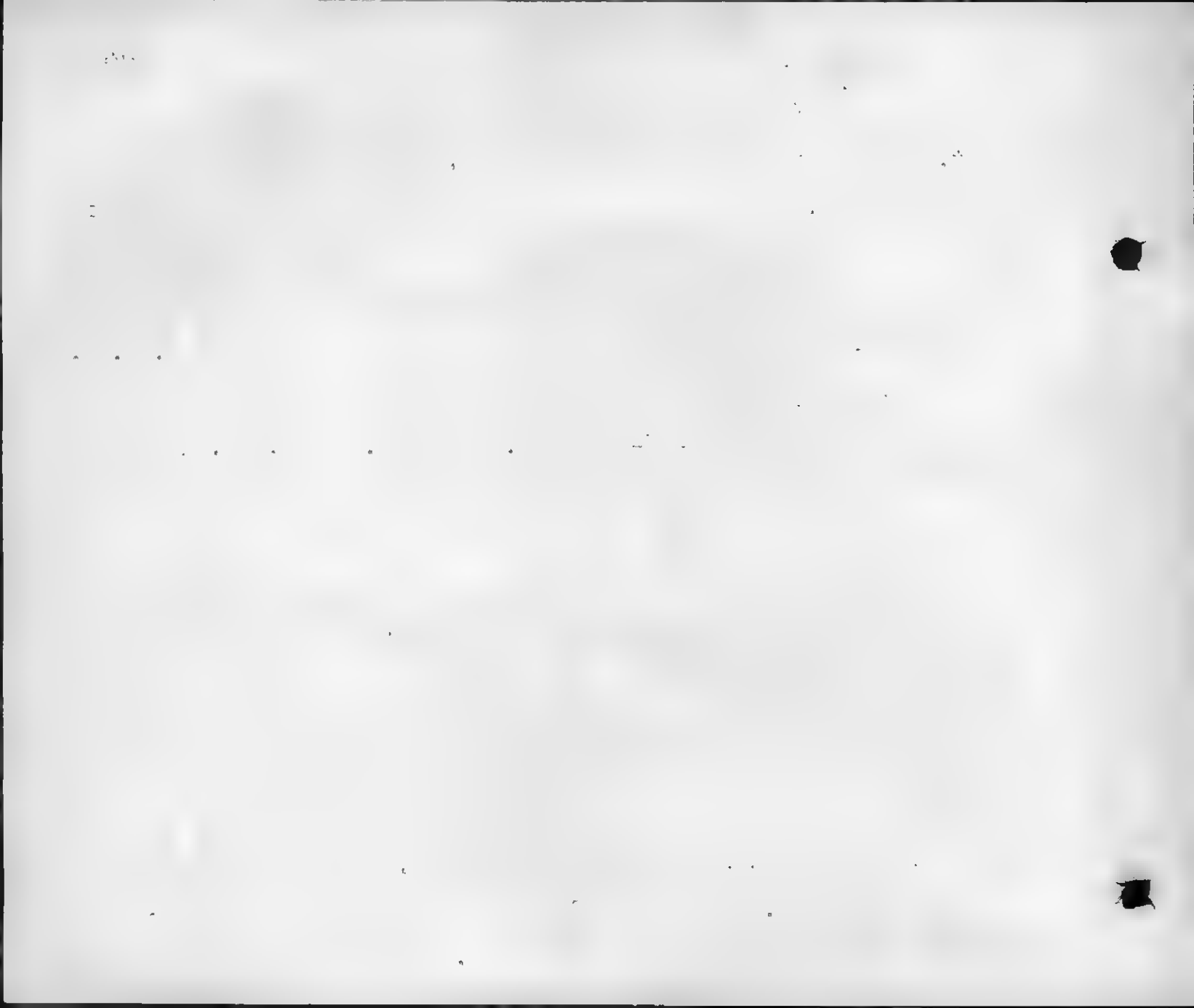
I

U

1

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Route 4		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Linganore		d. STREET ADDRESS Linganore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANK MCKINLEY ROHRBACK		4. DATE OF DEATH Oct. 21 1961	
5. SEX male	6. COLOR OR RACE white	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 18 April 1896
9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR: Months 65 Days 65 Hours 65 Min 65		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) farmer-retired		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Rohrback		14. MOTHER'S MAIDEN NAME Lydia Cochran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213-36-7786	
17. INFORMANT Mrs. Nellie G. Young, Mt. Airy Route 4		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO 16-X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Lungs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extensive metastatic carcinoma of liver, inanition.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 to 10/21/61 , 19____ that (I) (we) last saw the deceased alive on 10/20/61 19____, and that death occurred 10/21/61 from the causes and on the date stated above			
22a. SIGNATURE G. F. Meadors, M.D.		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.		22d. ADDRESS Damascus, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Oct. 1961	
23c. NAME OF CEMETERY OR CREMATORY Central Cemetery		23d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE D. H. Hartzler & Sons		ADDRESS Libertytown, Md.	
25a. REC'D BY REGISTRAR OCT 24 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



14
11406
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11392

1 PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1 RED 2	
3 NAME OF DECEASED (Type or print) First Middle Last HOWARD B SMITH		4. DATE OF DEATH Month Day Year Oct 9 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 9, 1903
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARRIER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. B. SMITH		14. MOTHER'S MAIDEN NAME FANNIE MOXLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30 9139	
17. INFORMANT A. B. SMITH		Address 7. d. c.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Cardiac occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c). Heart Block DUE TO Dissecting Aortic Aneurysm lying cause (c) 3 yrs +		INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1961 , to Oct 9, 1961 , that (I) (we) last saw the deceased alive on Oct 1, 1961 , and that death occurred at 2.2 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE B. Bothomas M.D.		22b. DATE SIGNED Oct. 12, 1961	
22c. PHYSICIAN'S NAME (Type) Bothomas, MD		22d. ADDRESS Fredrick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 13, 1961	
23c. NAME OF CEMETERY OR CREMATORY FREDERICK		23d. LOCATION (City, town, or county) (State) FREDERICK MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles C. C. C.		25a. REC'D BY REGISTRAR 16 '61	
ADDRESS FREDERICK, MD		25b. REGISTRAR'S SIGNATURE Charles C. C. C.	



1
 M
 I
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11407
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 11393

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 19 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 236 Dill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle LESTER Last SMITH		4. DATE OF DEATH Month October Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1891
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	11. IF UNDER 24 HRS Months 70 Days 70 Hours 70 Min. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Hood College	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Smith		14. MOTHER'S MAIDEN NAME Mary Geisbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 220-18-1799	
17. INFORMANT Mrs. Mary J. Smith (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 42111 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) afforded 10/7/61 for unperformed affording		INTERVAL BETWEEN ONSET AND DEATH mins days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10/7/1961 to 10/15/1961 that (I) (we) last saw the deceased alive on 10/15/1961 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Robert N. Pilgram M.D.		22b. DATE SIGNED 16 Oct 1961	
22c. PHYSICIAN'S NAME (Type) Robert N. Pilgram		22d. ADDRESS Pro E. Bldg, Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1961	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE OCT 19 1961	
25b. REGISTRAR'S SIGNATURE C. L. Kneass			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

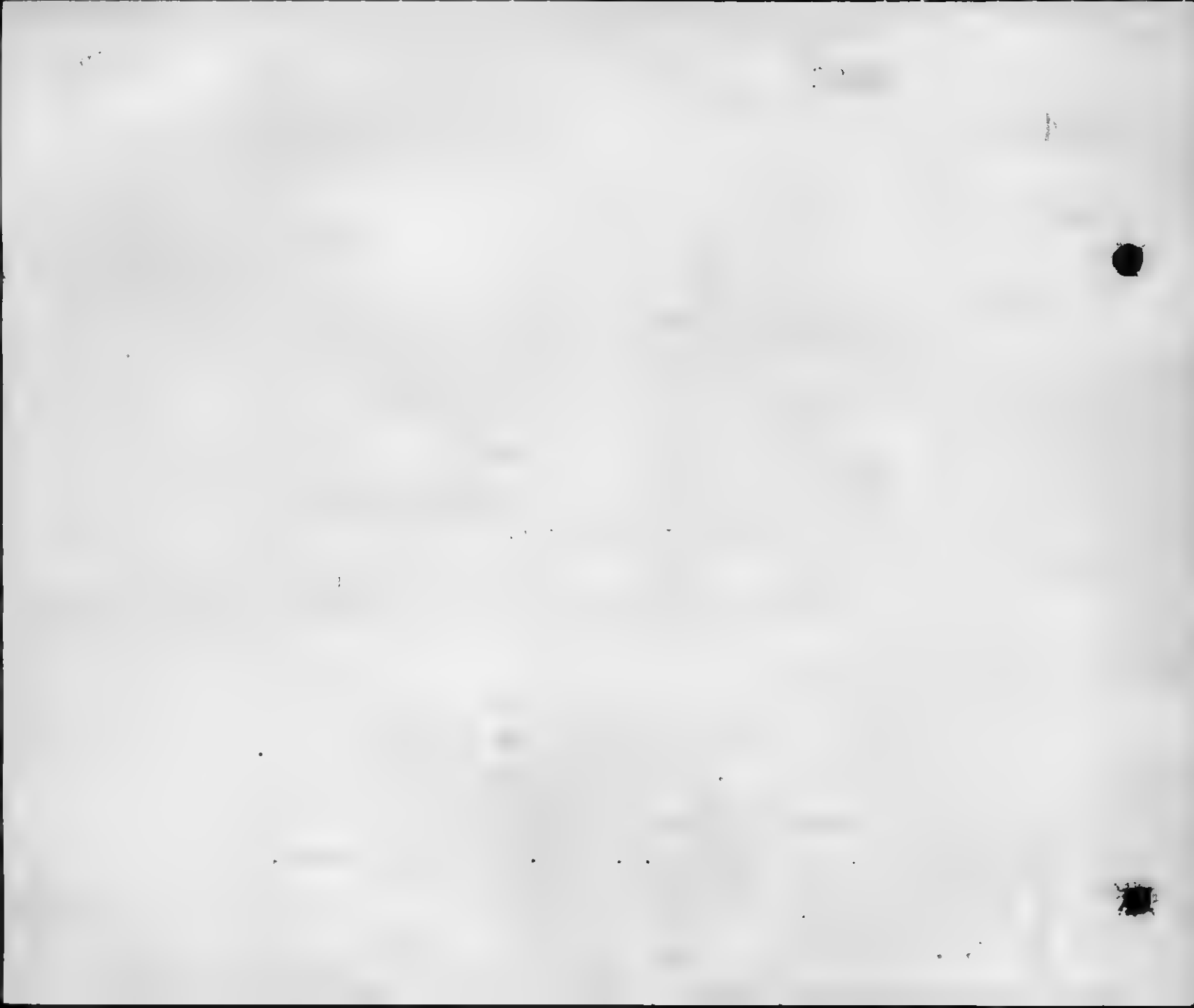
11408

11394

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartonsville Rt 6		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartonsville Rt 6	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bartonsville Rt 6		d. STREET ADDRESS Rt 6	
3. NAME OF DECEASED (Type or print) Harry Snowden		4. DATE OF DEATH Month 10 Day 28 Year 19 61	
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Lime cCo	11. BIRTHPLACE (County & State, or foreign country) Frederick, Md
13. FATHER'S NAME Greenberry Snowden		14. MOTHER'S M maiden name Jennie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Ida Brown		Address 122 East St Frederick, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO CORONARY ARTERY THROMBOSIS ARTEROSCLEROTIC HEART DISEASE GENERALIZED ARTEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 7 HR YRS YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from FEB. 26 19 61 , to OCT. 28 19 61 that (I) (we) last saw the deceased alive on OCT. 28 19 61 , and that death occurred at M , from the causes and on the date stated above			
22a. SIGNATURE Frank Damazo		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRANK DAMAZO M.D.		22d. ADDRESS 7 W. 3RD ST FREDERICK, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-31-61	23c. NAME OF CEMETERY OR CREMATORY Bartonsville	23d. LOCATION (City, town or county) (State) Bartonsville, Fred co, Md
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111		25a. REC'D BY REGISTRAR NOV 2 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

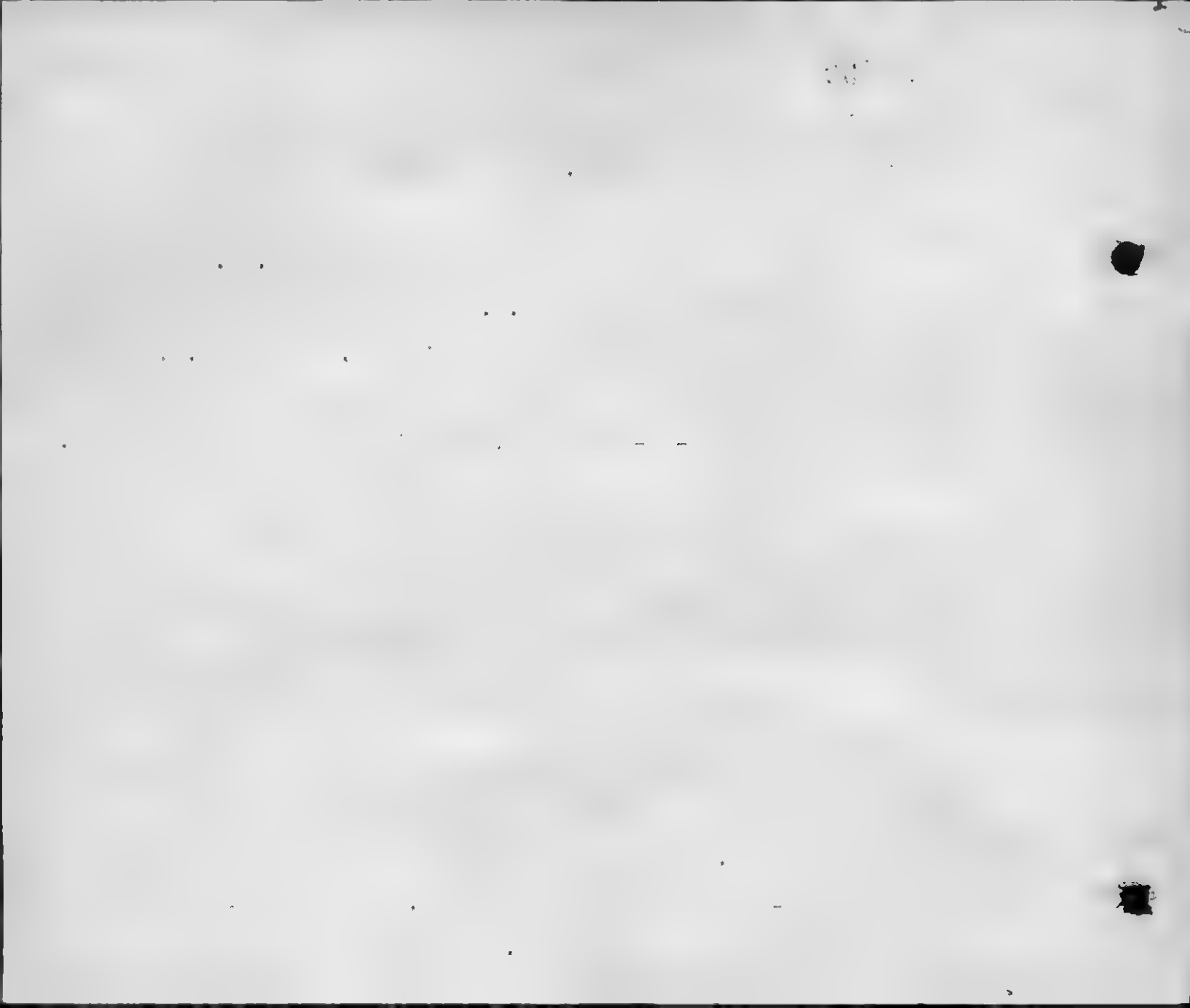
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11409

11395

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> c. LENGTH OF STAY IN 1b <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>At Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER FLORENCE STITELY</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>9.</u> Year <u>1961</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 3. 1896</u>		9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. MD</u>	
13. FATHER'S NAME <u>John Carty</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Weddle</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-03-2212</u>		17. INFORMANT <u>Mrs. Madeline Lewis</u> Address <u>Thurmont, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Atherosclerosis</u> DUE TO (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cerebral thrombosis + 4 years previously</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10-9-61</u> to <u>10-9-61</u> , that (I) (we) last saw the deceased alive on <u>10-9-61</u> , and that death occurred at <u>10:30 p.m.</u> from the causes and on the date stated above.		22. NATURE <u> </u>		22b. DATE SIGNED <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-12-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>United Brethren Cem.</u>	
23d. LOCATION (City, town or county) <u>Thurmont, Maryland</u>		23e. REC'D BY REGISTRAR <u> </u>		23f. REGISTRAR'S SIGNATURE <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Truager</u>		24b. ADDRESS <u>Thurmont, Md.</u>		24c. DATE <u>OCT 16 '61</u>	



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

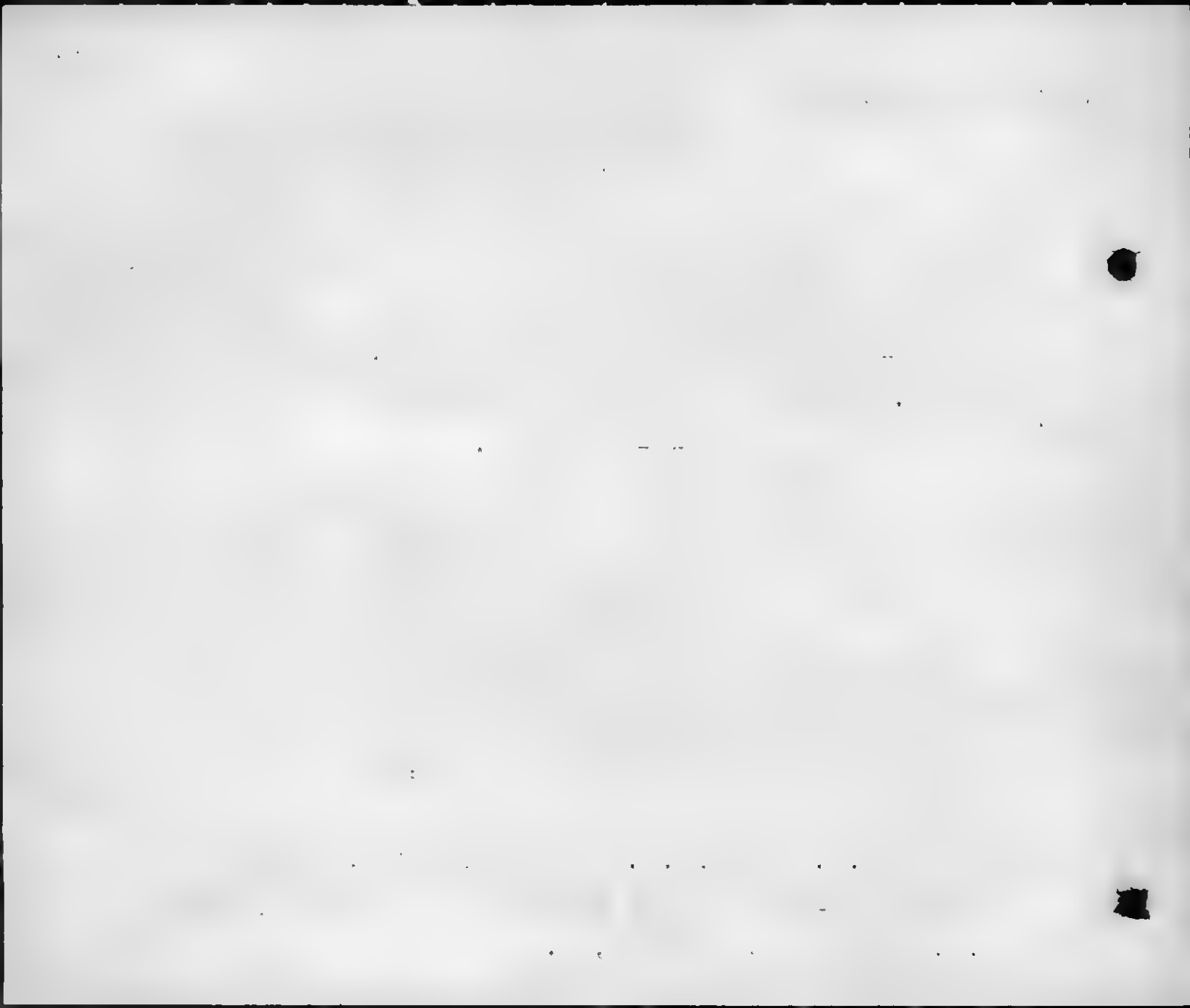
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11396

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 1 Year d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 108 West Third Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDYTH BOLLING SUMMERS		4. DATE OF DEATH Month October Day 28 Year 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 Dec 1915	
9. AGE (in years last birthday) 45 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 15 Hours 45 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		11. BIRTHPLACE (County & State, or foreign country) Buckeystown, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry D. Shankle	
14. MOTHER'S MAIDEN NAME Ossie Ponton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-09-0041		17. INFORMANT Hoyt J. Summers (Same as item #2) Address	
18. CAUSE OF DEATH (Enter on only one cause paragraph (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia DUE TO Leukemia Conditions, if any, which gave rise to immediate cause (b) Leukemia DUE TO Leukemia cause last, (c) Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Leukemia INTERVAL BETWEEN ONSET AND DEATH about 6 years			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1957 to Oct 28, 1961 , that (I) (we) last saw the deceased alive on Oct 25, 1961 , and that death occurred Oct 28, 1961 from the causes and on the date stated above.			
22a. SIGNATURE E. A. Dettbarn		22b. DATE SIGNED 29 Oct 1961	
22c. PHYSICIAN'S NAME (Type) E. A. Dettbarn, M. D.		22d. ADDRESS Walkersville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-61	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MR. R. ETCHISON & SONS		25a. REC'D BY REGISTRAR NOV 1 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kears		25c. ADDRESS Frederick, Md.	



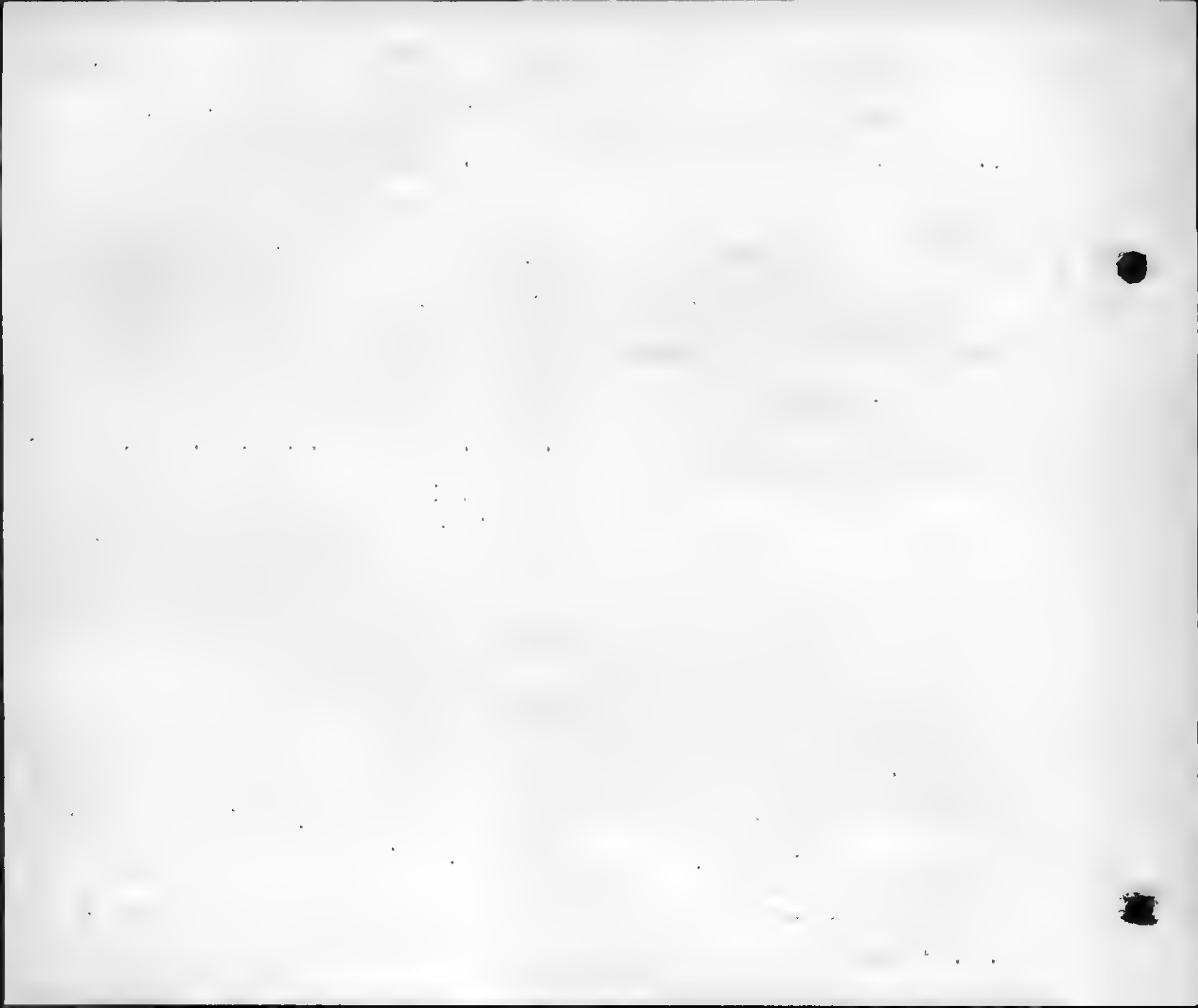
CERTIFICATE OF DEATH

Reg. Dist. No. 11397

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Rural #1		c. LENGTH OF STAY IN 1b 26 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Line Plant Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FERDINAND Middle THOMPSON Last THOMPSON		4. DATE OF DEATH Month October Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1871
9. AGE (In years lost birthday) 90 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Thompson		14. MOTHER'S MAIDEN NAME Mary Mahoney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Roy J. Thompson, R.D. #1, Mt. Airy, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure with Pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days - Several years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to Oct. 1961 , that I last saw the deceased alive on October 16, 1961 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell M.D.		ADDRESS (Street, city or town, state) 900 So. Main St. Mt Airy, Md DATE SIGNED 10/17/61	
PHYSICIAN'S NAME (Type) W.B. Culwell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-20-1961	22c. NAME OF CEMETERY OR CREMATORY Bush Creek Cemetery	22d. LOCATION (City, town, or county) (State) Monrovia Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 19 '61	
		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

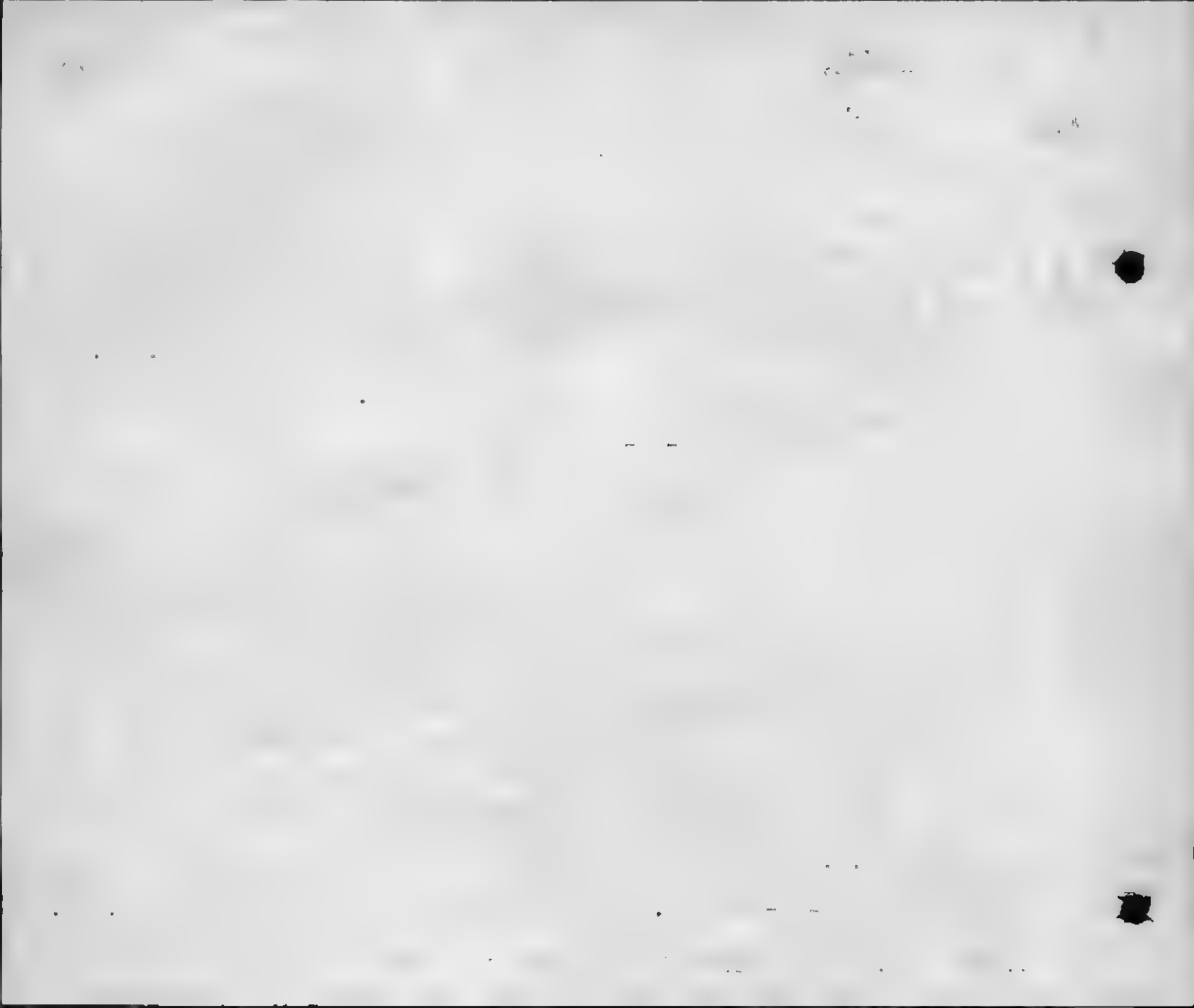


1
The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
11412
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11398

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Emmitsburg rural		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Emmitsburg rural	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS Own Home	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMORY ERNEST VALENTINE		4. DATE OF DEATH Month Day Year October 16 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Elmer Valentine		14. MOTHER'S MAIDEN NAME Helen M. Ohler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 17. INFORMANT 215-34-3966	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma prostate c metastases</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <i>Dec 1, 1955</i> to <i>Oct 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>Oct 15, 1961</i> , and that death occurred <i>8:15</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.R. Cadle</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W.R. Cadle		22d. ADDRESS Emmitsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		23d. LOCATION (City, town or county) (State) Rocky Ridge Fred. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond S. Creager</i>		25. REC'D BY REGISTRAR DATE OCT 19 '61	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11413

11399

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 2723 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 629 W. Fayette Str	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Holly Middle D Last Vaughan		4. DATE OF DEATH Month 10 Day 17 Year 1961	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-8-1897
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew M. Vaughan		14. MOTHER'S MAIDEN NAME J. Elizabeth George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 233-12-8369	
17. INFORMANT Record of Victor Cullen State Hosp. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis - 002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 02X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease - 420		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/4 1961 to 10/17 1961 , that (I) (we) last saw the deceased alive on 10/16 1961 , and that death occurred at 739 AM , from the causes and on the date stated above.			
22a. SIGNATURE Michael S. Davis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Michael S. Davis		22d. ADDRESS Cullen, Maryland	
23a. DATE OF CREMATION, REMOVAL (Specify) Oct 19-1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Willcrest Cem		23d. LOCATION (City, town, or county) (State) White Sulphur Sp. W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Quaglin		25a. REC'D BY REGISTRAR 1961	
25b. REGISTRAR'S SIGNATURE Richard S. Thane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

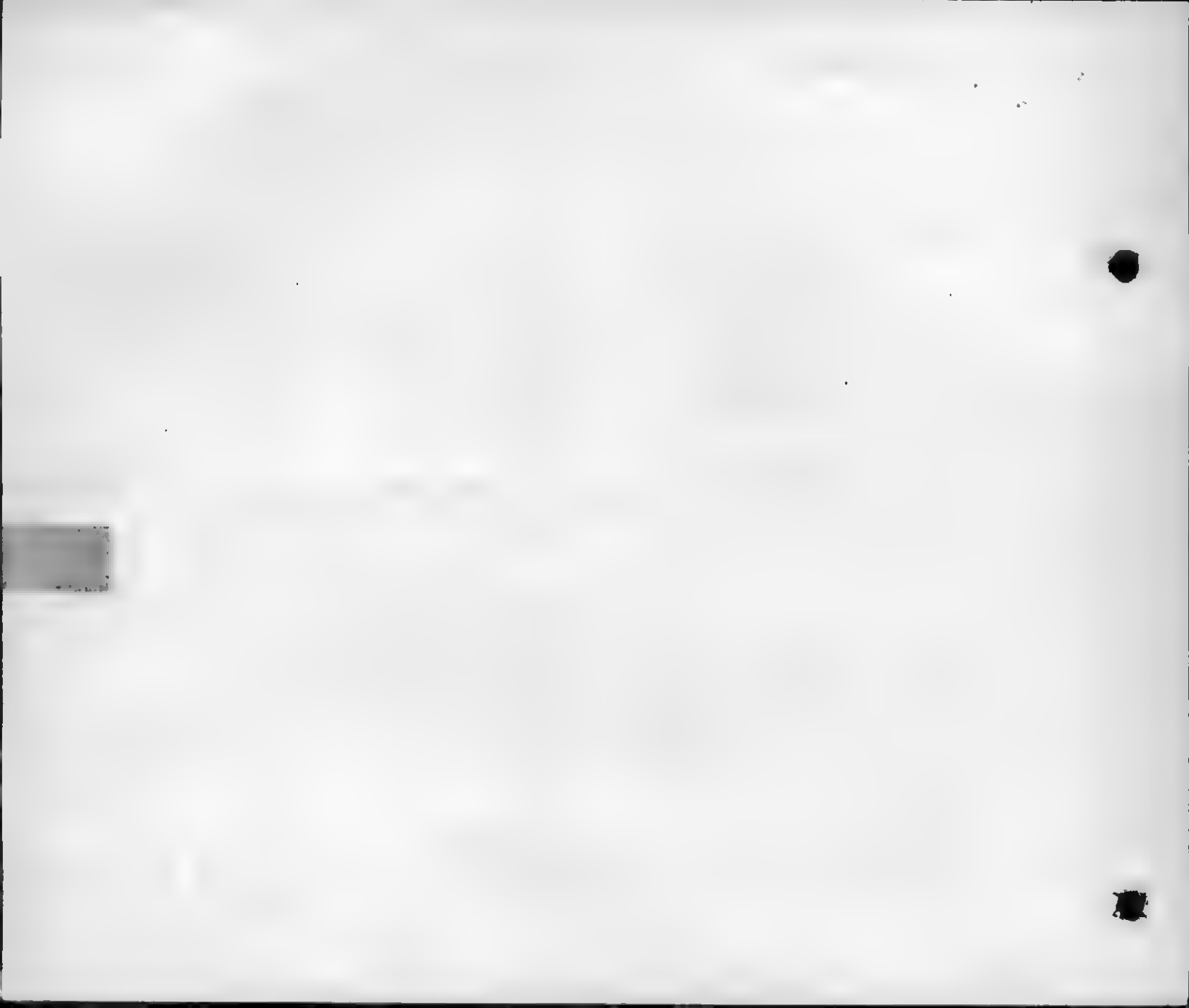
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4



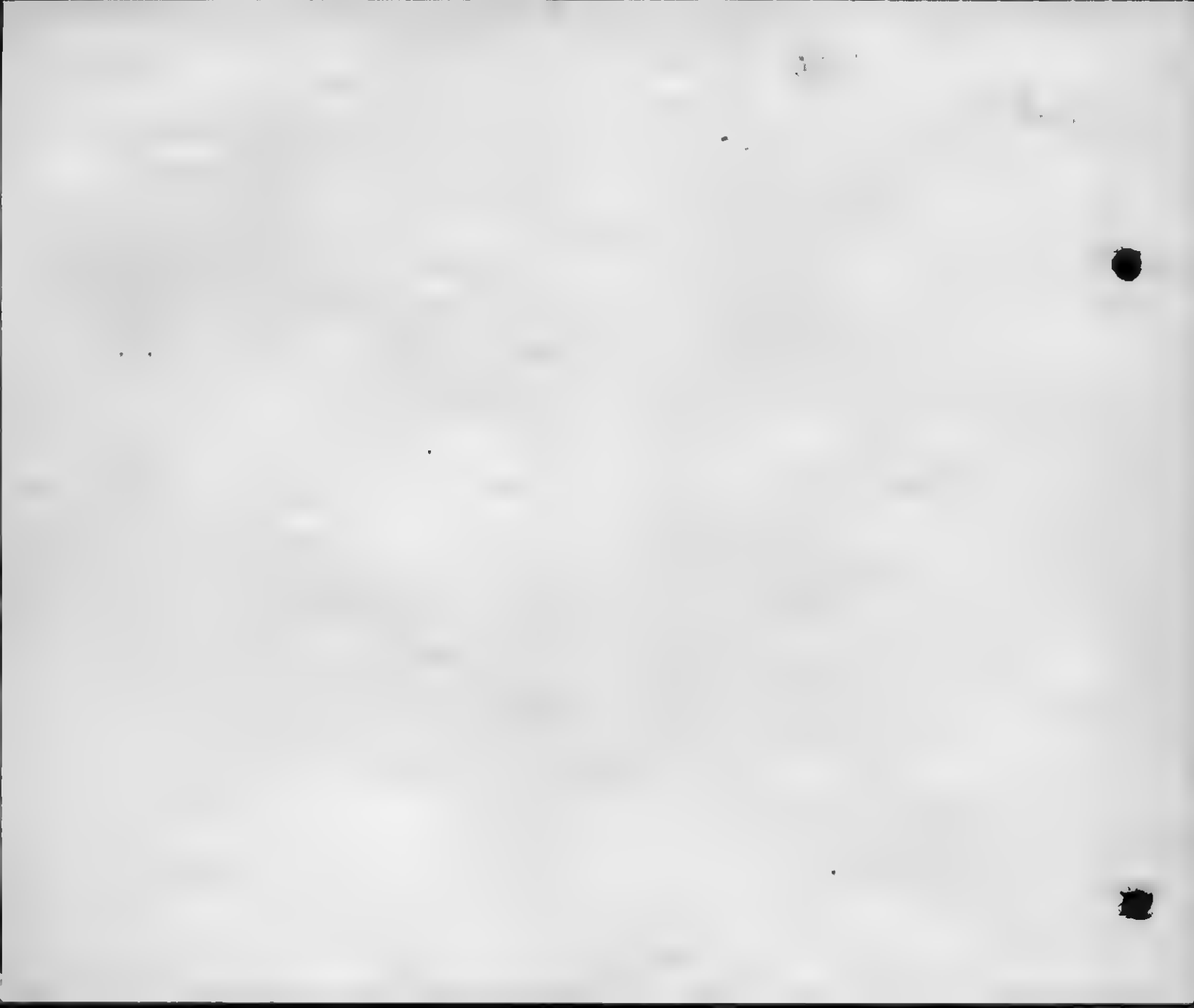
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13-P

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11414 CERTIFICATE OF DEATH 11400											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sunnyside c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sunnyside, Rt 4						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sunnyside Rt 4 d. STREET ADDRESS Sunnyside, Rt 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Bertha Middle Mae Last Weedon						4. DATE OF DEATH Month 10 Day 27 Year 19 61					
5. SEX Female						6. COLOR OR RACE negro					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Month 7 Day 8 Year 1883					
9. AGE (In years 1 birthday) 78 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Midwife						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or in country) Frederick, Co, Md						12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Charles Bowens						14. MOTHER'S MAIDEN NAME Kitty Calaman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. none					
17. INFORMANT Howard M. Weedon						Address Frederick, Co Rt 4 Sunnyside					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). INTERVAL BETWEEN ONSET AND DEATH Months years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1959 to 10/27 , 19 61 , that (I) (we) last saw the deceased alive on 10/25 , 19 61 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE James B. Thomas											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) James B. Thomas											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 10-30-61											
23c. NAME OF CEMETERY OR CREMATORY Sunnyside											
23d. LOCATION (City, town or county) (State) Frederick Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hilde III											
ADDRESS Frederick, Md											
25a. REC'D BY REGISTRAR NOV 2 '61											
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas											



1
10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
I
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11415
11401
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont			
c. LENGTH OF STAY IN 1b 1 yr				d. STREET ADDRESS 1 Park Lane			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) I Park Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM JOSEPH WILSON				4. DATE OF DEATH Month Day Year Oct. 19. 1961			
5. SEX Malr		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man				10b. KIND OF BUSINESS OR INDUSTRY Lehigh Cement Co			
11. BIRTHPLACE (County & State, or foreign country) Near Union Bridge, Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William W. Wilson				14. MOTHER'S MAIDEN NAME Susan Hildebride			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 213-03-1097			
17. INFORMANT Thomas W. Wilson				Address Thurmont, Md			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) ASCVD DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 4 days 15 yr			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 9/19/61 19 61 , to Oct 16 19 61 , that (I) (we) last saw the deceased alive on Oct 16 19 61 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas A. Love				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/61	
22c. PHYSICIAN'S NAME (Type) Thomas A. Love				22d. ADDRESS Thurmont, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 22, 1961		23c. NAME OF CEMETERY OR CREMATORY Graceham Cem.		23d. LOCATION (City, town or county) (State) Graceham Fredk. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager				ADDRESS Thurmont, Md		25a. REC'D BY REGISTRAR OCT 23 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Prasad			

81

10



11416 **MARYLAND STATE DEPARTMENT OF HEALTH**
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11402

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Keymar		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg	
		f. STREET ADDRESS 1 R.D.# 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle Barbara Last Wolfe		4. DATE OF DEATH Month October Day 21 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newark, Wayne Co. New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stell		14. MOTHER'S MAIDEN NAME Barbara Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT D. Fred Wolfe, Emmitsburg, R.D.#1, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 300.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Catatonic Schizophrenia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16/61 19 to 10/21/61 19, that (I) was last saw the deceased alive on 10/21/61 19, and that death occurred 10:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE J. H. Caricofe		22b. DATE SIGNED 10/21/61	
22c. PHYSICIAN'S NAME (Type) J. H. CARICOFE		22d. ADDRESS Union Bridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Union Bridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		25a. REC'D BY REGISTRAR DATE OCT 24 '61	
ADDRESS Emmitsburg, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

C. E. Wilson

The following table shows the results of the experiments conducted during the year 1911. The first column gives the date of the experiment, the second column the name of the person who conducted it, and the third column the results obtained. The results are given in the form of a table, the first column of which gives the date of the experiment, the second column the name of the person who conducted it, and the third column the results obtained. The results are given in the form of a table, the first column of which gives the date of the experiment, the second column the name of the person who conducted it, and the third column the results obtained.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11417

11402

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blue Ridge Rural Summit</u>		c. LENGTH OF STAY IN 1b <u>11 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tipahato Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>California</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>316 Ash. St. 75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Young</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1926</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Niycr Young</u>		14. MOTHER'S MAIDEN NAME <u>Anna Shure</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. George Byrne</u>		Address <u>Blue Ridge Summit</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Status convulsivus</u> <u>353.2</u> DUE TO Candilions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Mar 1961</u> to <u>23 Oct 1961</u> , that (I) <u>we</u> last saw the deceased alive on <u>23 Oct 1961</u> and that death occurred at <u>230A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry H. Youngs Jr</u>		22b. DATE SIGNED <u>10-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY H. YOUNGS JR</u>		22d. ADDRESS <u>Blue Ridge Summit, PA.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Society</u>		23d. LOCATION (City, town, or county) (State) <u>Fayette Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. York</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 24 '61</u>	
ADDRESS <u>Warrenboro Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Rine</u>	

HEAD OF THE RIVER

1911

1911

1911

1911

1911